Single Point of Entry Long-Term Living Resource System Team Report

Dept. of Elder Affairs

Final Report

December 2008

Single Point of Entry Long-Term Living Resource System Team

Dept. of Elder Affairs

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Acknowledgments

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Senator Amanda Ragan
Representative Tyler Olson
Representative Linda Upmeyer

The Department also thanks State Senator Amanda Ragan and State Representative Linda Upmeyer for sponsoring HF 451, which led to this report.

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Resource Team Activities

House File 451 (**Appendix B**) charged the Iowa Department of Elder Affairs (DEA) with convening and staffing the Single Point of Entry Resource Team to make recommendations about the structure and means for providing a single point of entry to long-term care or long-term living resources in Iowa. Daniel Ernst, DEA Commission Chair, served as Chair. During the first Team meeting in Council Bluffs, on December 17, 2008, representatives from the U.S. Administration on Aging, AARP, and the Lewin Group presented an overview of single entry point systems in other states – their successes, challenges, and lessons learned. During the next meeting in Des Moines, on February 22, 2008, the Team further refined operational procedures and constructed a mission statement - *"To recommend the best single point of entry system for all Iowans who need or will need long-term care."* Key issue areas identified through the course of the discussion were Access, Coordination, Marketing-Education Awareness, Accountability, Cost, and Culture/Societal Change.

The April 11, 2008, meeting in Oskaloosa focused on the trends and structures of Aging and Disability Resource Centers (ADRCs) across the nation using "Fully Functioning" criteria, specifically:

Awareness and Information
Assistance
Access
Target Populations
Critical Pathways to Long-Term Support
Partnerships and Stakeholder Involvement
IT/Management Information Systems
Evaluation Activities
Staffing and Resources

A chart providing more explanation of each category can be found in **Appendix C**.

During the 2008 Legislative Session, clarification was provided by members of the General Assembly that the target population for the Team's efforts should be persons age 60 and older and that the Team was to develop proposals for an enhanced and coordinated method of accessing existing services rather than creating new structures. A form was identified for Team members to use to submit suggestions for recommendations to be considered for possible inclusion in the final report.

At the July 14, 2008, meeting in Des Moines, information was shared about the single entry point systems in seven selected states followed by a presentation covering the Lewin Group's assessment of Iowa's progress towards a "Fully Functioning Single Entry Point Process/ADRC." Proposed recommendations (**Appendix A**) received prior to the meeting were distributed to Team members. Discussion began on the recommendations and continued through the next meeting, on August 18, 2008, in Des Moines.

Some of the themes made during Team member discussions were:

- There is no right or wrong single entry point model. Each state's configuration is reflective of the history and strengths within that state.
- A single point of entry process is not constructed overnight. Other states have found that making incremental change over time yielded a system that is more sustainable than one that is imposed or executed quickly.
- Creating a single point of entry system is an on-going process. There is no definitive point where the system is complete. It is continually evolving.

Section One: Why a Single Point of Entry

Why a Single Point of Entry?

- *2007 US Dept of Health and Human Services report found 7 out of 10 nursing home residents say they are there in part because they didn't know there were options.*

Sources: US AoA, The Lewin Group

This report details the activities of the Single Point of Entry Resource Team. Section two describes a fully functioning Single Point of Entry/Age and Disability Resource Center and outlines the progress Iowa has already made in this area. Section three outlines the team's recommendations about how to move forward in the development of an informational single point of entry process in Iowa. The appendices provide background information used by the Team to develop recommendations.

As the comments below from Iowans confirm, making Iowa's long-term care system work to meet consumer needs is a challenge. The network of services, agencies, and programs has been described by some as fragmented, confusing, insensitive, and unyielding. For Iowans most in need, the challenge can be too daunting.

> *"You have to be a detective to negotiate the maze of (long-term care) services out there."*
>
> *"Families do not know where to turn to for support. They often feel like they are going it alone."*
>
> *"You have to be very savvy, willing to do a lot of research on your own, and just hope you happen on good information."*
>
> *"It is all very time consuming and you often feel overwhelmed. Nothing is simple or easy."*

Legislative and Executive Branch policymakers recognized that access to information regarding all components of the long-term living resource system is necessary to empower consumers in planning, evaluating, and making decisions to appropriately meet individual long-term living needs. (See **Acknowledgments** for a list of workgroup members.)

Section Two: Background on Fully Functioning Single Entry Point/Age and Disability Resource Center

The Aging and Disability Resource Center (ADRC) Technical Assistance Exchange identifies nine key elements of a fully functioning Single Entry Point (SPE)/ADRC. The criteria are recommended measures intended to be applicable across different types of ADRC models.

Fully functioning Single Point of Entry System — Key Elements:

1. Public Education

2. Assistance

3. Access

4. Target Populations

5. Critical Pathways

6. Partnerships & Stakeholders

7. IT/MIS

8. Evaluation

9. Staffing & Resources

Depending on the model of ADRC a state is implementing, the term SEP/ADRC may be interpreted to represent a) one operating organization in each community at the local level, b) a network of organizations serving as operating partners in each community at the local level, or, c) a combination of state and local level organizations operating in partnership. The key elements include:

1. **Public education**

A) ADRCs serve as highly visible and trusted places where people can turn for the full range of long-term support options.

B) Actively promote public awareness of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.

2. **Assistance**

A) ADRCs provide information and counseling to help people assess the potential need and eligibility for all available long-term support options, both public and private.

B) ADRCs link consumers with needed support through appropriate referrals to other programs and benefits and may track client intake, needs assessment, and care plans.

C) ADRCs establish collaborative relationships with programs that provide home and community-based services, including the Senior Health Insurance Information Program, National Family Caregiver Support Program, Alzheimer's' Disease services, health promotion and disease prevention programs, transportation, employment, housing, adult education, and others.

D) ADRCs consistently conduct follow-up when needed to determine outcome of options counseling.

E) ADRCs enable people to make informed, cost-effective decisions about long-term care.

F) ADRCs ensure people are connected to appropriate crisis intervention services.

G) ADRCs assist individuals to plan for future long-term care needs.

3. **Access**

A) Eligibility screening; assistance in gaining access to private-pay long-term support services; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination that is integrated or closely coordinated with Resource Center services; one-stop access to all public programs for community and institutional long-term support services.

B) ADRCs serve as the entry point to publicly funded long-term care.

C) ADRCs have necessary protocols and procedures to facilitate access (intake, eligibility, assessment) to public programs that are integrated or closely coordinated the process is seamless for consumers.

D) ADRCs support help to reduce the cost of long-term care by delaying or preventing the need for more expensive public long-term care services.

Nearly all 370,000 Iowa AARP members say it is important to remain in their own homes as long as possible if they need long-term care services.

- AARP 2002 survey.

4. **Target Populations**

A) ADRCs serve older adults and at least one target population of people with disabilities (e.g. physical; developmental/mental retardation; mental illness). ADRC projects should move toward the goal of serving persons with disabilities of all ages and types.

5. **Critical Pathway to Long Term Supports**

A) ADRCs create formal linkages between and among the critical pathways to long-term support.

6. **Partnerships & Stakeholder Involvement**

A) ADRCs have documented support and active participation of the State Unit on Aging, the State Medicaid Agency, and the State Agency(s) serving the target populations of people with disabilities.

B) ADRCs establish strong partnerships with the State Health Insurance Information Program (SHIIP) and other programs instrumental to ADRC activities. Examples of other programs include Alzheimer's disease programs, Area Agencies on Aging, Centers for Independent Living, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers, and other community-based organizations.

C) ADRCs meaningfully involve stakeholders, including consumers, in planning, implementing, and evaluation activities.

7. **Information Technology/Management Information Systems**

A) The ADRCs have a management information system that supports the functions of the program, including tracking client intake, needs assessment, care plans, utilization and costs.

8. **Evaluation Activities**

A) At a minimum, ADRCs must have performance goals and indicators related to visibility, trust, ease of access, responsiveness, efficiency, and effectiveness.

9. **Staffing and Resources**

A) ADRCs have adequate capacity to assist consumers in a timely manner with long-term supports requests and referrals.

B) ADRCs have an individual assigned to be the overall leader of all SEP/ADRC operations. It is particularly important to have an overall leader with sufficient authority to maintain quality processes when functions occur in more than one location or agency.

C) ADRCs have conducted an assessment of potential funding sources such as Medicaid Federal Financial Participation, foundations, and community organizations.

Section Three: Iowa's Progress on Single Entry Point/Age and Disability Resource Center

Iowa's progress toward a fully-functioning SEP/ADRC

- *Collaboration across aging and disabilities communities*
- *Statewide database*
- *State leadership and legislative supporting SEP development*

In March 2008, The Lewin Group, which serves as the Administration on Aging (AoA) ADRC technical assistance contractor, presented its assessment of the progress that Iowa has made toward realizing the AoA/CMS vision of a fully functioning ADRC. Major areas of strength include collaboration across aging and disabilities communities, a statewide database, and state leadership and legislation supporting SEP development. Major areas for growth include coordinating ADRC activities with a state plan for a SEP system, streamlining access at the local level, and piloting options counseling and streamlined processes at the local level. The full report can be found in **Appendix D**.

The Single Point of Entry Resource Team recognized that Iowa is already has a base to assemble a more expansive single entry point process. The goal was to build on the existing foundation using best practices and protocols utilized in other states and to provide logical and tactical next steps. The existence of awareness efforts, partnerships among state agencies, linked database resources, LifeLongLings.org, options counseling pilot projects and strong community presence by an array of providers linked by area agencies on aging and centers for independent living give the state a leg-up on others that may be starting from scratch.

Other States

Representatives from the Administration on Aging (AoA), The Lewin Group, and AARP presented information to the Team about facets of single entry point processes in other states. In total, components of 14 other state systems were reviewed.

Presentations from AoA and The Lewin Group served as an informational starting point for the Team by explaining the history and current status of Aging and Disability Resource Centers across the nation. Presenters described what a coherent long-term care system would look like and how other states have moved forward in streamlining consumer access to services and supports. An important overarching concept that ran throughout the presentations was that "Single Point of Entry is not about replacing existing organizations and networks. It is about building a better, more coordinated network."

Where Iowans turn for help with navigating long-term care choices:

Religious Support	*.2%*
AAA	*2.9%*
Self	*5.6%*
Other	*8.6%*
Relative or Friend	*11.4%*
Medical Support	*30.4%*
Don't Know	***37.5%***

Source: Iowa 2000 Behavioral Risk Factor Surveillance System.

AARP Iowa reported the results of in-depth telephone surveys conducted with policymakers in seven selected states – Illinois, Maryland, Minnesota, Nebraska, New Jersey, Nevada, and Oregon. Survey questions covered key topics such as funding, partnerships, operational components, challenges, processes, evaluation/QA, marketing/public education, and electronic health records.

Common themes emerged from this "snapshot" of the seven states surveyed. Many states said that they had not developed their system as far as they had hoped up to this point. Most states report that developing single entry point systems is a process that is ongoing, evolves, and takes continued commitment. All states surveyed said that adequate and ongoing funding is the critical factor to successful development of fully functioning SEP/ADRCs. The full report can be found in **Appendix E**.

Section Four: Recommendations

The Resource Teams' recommendations are organized around key components of the "Fully Functioning Single Point System/ADRC Criteria," specifically Awareness & Information, Assistance, Access, Evaluation Activities, and Staff and Resources. The criteria were developed by The Lewin Group to assist states in measuring and assessing their progress towards a fully functioning system.

Awareness and Information which incorporates activities that provide public education and information about long-term support options such as an outreach and marketing plan, a comprehensive resource database, consistent and uniform information, and service to private pay consumers in addition to those who utilize public assistance.

> **Recommendation #1:** Seek an increase in funding provided to the Department of Elder Affairs during the 2009 Legislative Session in the Health Care Reform Act to expand the initiative to promote general awareness regarding long-term living needs and resources through community partners, posters, brochures, handouts, and television and radio spots. Also, educate and link all appropriate associations, including, but not limited to medical providers, pharmacy association, advanced funeral planning, death, dying, and bereavement, homecare, Alzheimer's disease, and mental health to [*the*] LifeLongLinks [*website*].

The Resource Team believes that this will mean that more Iowans will become aware of the tools available to help them navigate the maze of long-term care choices. As a result, more Iowans will access services in the setting of their choice and avoid more expensive and more restrictive long-term care environments.

Assistance such as long-term support options counseling, benefits counseling, employment options counseling, referral to other programs and benefits, crisis intervention, and helping people to plan for their future long-term care needs.

> **Recommendation #2:** Enhance the Iowa Family Caregiver hotline service so that consumers who need additional information on Medicare and Medicaid services and long-term care insurance may be transferred to information specialists, including but not limited to the Senior Health Insurance Information Program (SHIIP) and vice-versa. Also, expand pilot projects of Local Options Counselors, link applications and forms to assistance programs to the Life Long Links web site.

The Resource Team believes that this will provide seamless access to critical pathways for Iowa consumers searching for a variety of types of services and supports. As a result, more Iowans will more easily obtain information that helps them become informed consumers as they purchase desired services or plan for their future long-term care needs.

Access including eligibility screening, assistance in gaining access to private-pay long-term support services, comprehensive assessment, programmatic eligibility determination, Medicaid financial eligibility determination that is integrated or closely coordinated with the Aging and Disability Resource Center services, one-stop access to all public programs for community and institutional long-term support services.

Recommendation #3: Seek adequate funding to allow for the integration of Life Long Links, the Family Caregiver hotline, COMPASS, and 2-1-1 databases. Also, include funding for brick and mortar ADRC sites, utilize the no wrong door approach, and build upon existing infrastructure.

The Resource Team believes that this will provide an integrated IT/MIS infrastructure that provides consumers with the type of information about supportive services no matter what website or toll-free telephone service they use. This will minimize confusion for consumers and expedite their access to supportive services provided in the setting they choose.

The concept of integration is important to the Team because it acknowledges the importance to consumers of finding desired information about – and access to – multiple home and community-based services, employment assistance, transportation, crisis/emergency service, residential and housing without researching and contacting an endless series of entities on a trial and error basis. As such, integration ensures that multiple systems are connected, coordinated and working together so that consumers end up with their needs met with minimal effort and anxiety.

Recommendation #4: Explore and identify federal, state, and market-based methods that may include, but are not limited to presumptive eligibility, fast track pilot projects under Medicaid, a standardized comprehensive assessment tool, and the use of electronic health records with the goal of expediting service system delivery.

The Resource Team believes that analyzing methods of access, eligibility, and delivery models that ease access to and expedite the delivery of long-term care services will lead to continuous improvements in the overall delivery of long-term care. As a result, Iowa's long-term care system will benefit from the knowledge of existing or emerging innovations and can then determine whether they make sense to adopt in this state.

Evaluation Activities consisting of, at a minimum, performance goals and indicators related to visibility, trust, ease of access, responsiveness, efficiency, and effectiveness.

Recommendation #5: Utilize the Senior Living Coordinating Unit (SLCU) as the structure to ensure long-term coordination and accountability including an evaluation component of the single point of entry system.

The Resource Team believes that this will ensure that limited resources are maximized so that consumers receive high quality service and have recourse to protect their rights. It will ensure that tracking mechanisms are in place that support consumer confidence and captures data that demonstrates accountability of the system to the people it serves and the State. This will lead to higher consumer satisfaction and continual quality improvements in the single entry point system as it develops and evolves with shifting consumer demand.

Staffing and Resources which relate to efforts to pursue private and public funding opportunities to create sustainable programs and ensure that adequate capacity exists to assist consumers in a timely manner with long-term support requests and referrals.

Recommendation #6: Explore all options for sustainable funding for a Single Point of Entry System.

The Resource Team knows the Iowa ADRC was made possible through a federal grant from the U.S. Administration on Aging, which concluded in September 2008 for FY 2009, the General Assembly provided funding to sustain the program and implement two pilot projects at the county level utilizing Option Counselors. Additional and redirected state and federal resources will be needed to craft the Single Entry Point. The Resource Team strongly believes that all other sources of private and public funding should be pursued to supplement limited state and federal funding.

Section Five: Observations and Concluding Remarks

Due to the fragmentation in public programs and information deficit, many Iowans currently lack access to quality information on community-based long-term care services. This long-standing condition is a significant factor in over-utilization of institutional care.

Through the use of a single entry point system, such as the Aging and Disability Resource Centers (ADRCs) developed by the Administration on Aging and the Centers for Medicare and Medicaid Services (CMS), the aging service network can provide individuals and their families with streamlined, comprehensive, and reliable information that will help consumers make informed decisions about long-term care.

ADRCs integrate outreach, information, and options counseling for home and community-based long-term care. This component builds on the current statewide network of the Department of Elder Affairs and the Area Agencies on Aging, as well as complementary programs. Iowa is fortunate to have been among 43 states to receive federal grants to start an ADRC, but it is clear from this report that much work remains in order to develop a fully functioning single point of entry system.

ADRCs/SEPs initiatives do not create new entitlement programs, but rather seek to serve more people in the community while helping to alleviate fiscal pressures on Medicaid. The goal of a single point of entry information system is to reach out to all consumers and caregivers who have the need for information on long-term care before they make irreversible decisions, ideally including younger adults who need to prepare in advance for their future long-term care needs.

Federal agencies expect states to develop ADRCs that will provide information, options counseling, and referrals to individuals who can and will finance their own care, as well as those who may be eligible for support through the full array of programs available in the community. If targeted and managed properly, the ADRC/SEP will cost less overall than if the aging services community maintains the current patchwork approach to services.*

The Department of Elder Affairs has circulated this report among the many stakeholders in Iowa's fragmented long-term care system. In consultation with the Commission on Elder Affairs, it will

work in collaboration with public and private funding partners to develop and implement the Resource Team's recommendations.

* According to an analysis by the Lewin Group conducted for the National Association of State Units on Aging and the National Association of Area Agencies on Aging.

Appendices

Appendix A

Proposed Recommendations as Submitted

The following matrix reflects all the suggested recommendations that were submitted and considered by stakeholders in the development of the six final recommendations.

Single Point of Entry Resource Team Proposed Recommendations

Seek an increase in funding provided to the DEA during the 2008 Legislative Session in the healthcare reform legislation to expand the initiative to promote general awareness regarding aging services through community partners, posters, brochures, handouts, and television and radio spots.		DEA
Provider Awareness / Marketing of SPE to professionals.	Berdette Ogden	DPH
Public Awareness / Marketing of SPE.	Berdette Ogden	DPH
Work with a representative of the Iowa Pharmacy Association to provide a link on the Life Long Links web site to an informational piece on services available by pharmacists to home bound or long-term care residents.	Nichole Schultz	IA. Pharmacy Assn.
Support current efforts to establish high quality information concerning LTC that is available electronically. Pay particular attention to the provision of information and resources that address needs of older Iowans with mental health problems who have long-term care needs	Kitty Buckwalter	IA. Coalition on Mental Health and Aging
That information regarding the planning of one's funeral in advance, with the additional option of possibly funding, be included in the Single Point of Entry Resource Team's information.	Scott Eriksen	Hamilton's Funeral Home
To include information and resources on death, dying, grief and bereavement for residents of Assisted Living facilities.	Trudy Holman	Hamilton's Funeral Home
Iowa's SEP system should use the existing Iowa Information and Referral Network.	Robert Bacon	CDD
IAHC will provide Awareness and Information.	Mark Wheeler/Kim Anderson	IA. Alliance in Home Care

Funding for the existing Information and Referral (I&R) network needs to be adequate and sustainable to support basic operations (i.e. sufficient staff, marketing, database entry and updates).	Robert Bacon	CDD
Improve Accessibility of LifeLongLinks/SPE through phone line and off-line personal component, in conjunction with educational component to both the public and providers.	Anthony Carroll	AARP
The Alzheimer's Association chapters in Iowa should be contracted with to provide training and technical assistance to single point of entry providers on Alzheimer's disease, recognizing symptoms and warning signs and other topics as needed.	Carol Sipfle	Alz. Assn.
IAHC will provide Partnerships and stakeholder involvement.	Mark Wheeler/Kim Anderson	IA. Alliance in Home Care
IAHC will provide a web site that will link all Iowans to home care services which is a part of the long-term solution achieving a seamless entry system.	Mark Wheeler/Kim Anderson	IA. Alliance in Home Care
Enhance the Family Caregiver Hotline service so that consumers who need additional information on Medicare and Medicaid services and long-term care insurance may be transferred to information specialists with the Senior Health Insurance Information Program (SHIIP) and vice versa.		DEA
Expand the local Options Counselor pilot project statewide by using a phased-in approach over a six-year period. Beginning in FY 2010, add three Options Counselors at a cost of $255,000 each year through FY 2015 for a total estimated cost of $1.5 million.		DEA
Make available on Life Long Links, linkages to actual applications/forms needed for the various assistance programs.	Barb Morrison	SW 8 Senior Services
Seek adequate funding to allow for the integration of the Life Long Links, Family Caregiver, COMPASS, and 2-1-1 databases.		DEA
Explore the feasibility of, and funding necessary to, merge the elder and disability databases into the software used by COMPASS to create a single database using the AIRS taxonomy codes that is searchable via the internet by staff from both I & R systems.	Robert Bacon	CDD
That Iowa’s single point of entry utilizes a telephone system that is based on a simple easy telephone number, whether this be 211 or 311 or something like 800-555-2372 (LLL-ADRC).	Bob Welsh	SLCU Consumer Member
Determine which existing provider organizations could be utilized to serve as actual "brick and mortar" ADRC service centers for consumers.		DEA

That Iowa's single point of entry do everything it can to expedite the delivery of service. This might include encouraging the co-location of those who assess need, determine eligibility, and authorize expenditure, to help expedite the process. This also might include developing a method of presumptive eligibility that does not put the state at risk financial.	Bob Welsh	SLCU Consumer Member
That Iowa use LifeLongLinks as "the management information system that links the resources available in order to provide a single electronic point of entry to the long-term living resource system…	Bob Welsh	SLCU Consumer Member
That Iowa use the "no wrong door" approach and establish an ADRC within 30 miles of every Iowan by 2011, coordinated by the Senior Living Coordinating Unit.	Bob Welsh	SLCU Consumer Member
That the single point of entry in Iowa be designed to serve all persons who need long-term care.	Bob Welsh	SLCU Consumer Member
Ultimate goal must best service to the customer for the $ available. Utilize the in-place resources of the user friendly LifeLongLinks ADRC as a stepping stone for SPE in Iowa – merging the resources of other avenues with LLL as appropriate, establishing linkages and improving the accessibility of service with phone line and off-line (options counselor/ADRC personnel). Marketing will also be important.	Eve Casserly	Older Iowans Legislature
Utilize the existing Information and Assistance services offered through each area agency on aging through trained and certified AIRS (Association of Information and Referral Services) counselors to offer face-to-face options counselors and specialized aging information services.	Donna Harvey	Iowa Assn. of Area Agencies on Aging
Any recommendations on developing a single point on entry system should include Iowa's current single point of entry system into the long term care system for older adults that are implemented via the Area Agency on Aging (i4a) network and the Iowa Department of Elder Affairs.	Liz Silk	Heritage AAA
Utilize the already existing Lifelong Links (Aging and Disability Resource Center) concept administered through DEA in collaboration with DHS to identify Lifelong Links as the 'single point of entry' in Iowa. Using Lifelong Links as a base and using the resources offered through the nationwide network of Aging and Disability Resource Centers and the Lewin Group, the base for the single point of entry is in place and now is ready for expansion.	Donna Harvey	Iowa Assn. of Area Agencies on Aging
Propose federal policy changes that permit states to receive federal reimbursement for services delivered to aging applicants during the period their Medicaid eligibility is being decided.		DEA

Propose legislation that allows for presumptive eligibility for individuals who are being discharged from a hospital to a Medicaid home and community-based waiver program.		DEA
Propose legislation that allows for the implementation of a "fast track" pilot project that will include expediting the Medicaid financial application and determination of disability.		DEA
That Iowa utilize a standardized, comprehensive, independent assessment to be done prior to entry into a long-term care facility.	Bob Welsh	SLCU Consumer Member
As one-stop shops are being formed throughout Iowa's single point of entry/aging and disability resource center, we would recommend that a single comprehensive assessment be developed and required for all access points -- telephone, web, or face-to-face.	Donna Harvey	Iowa Assn. of Area Agencies on Aging
SPE/IDEA/IDPH/DHS oversee the establishment of a standardized, comprehensive, independent assessment to be given an individual prior to out of home placement in order to determine what level services (including placement) is needed.	Eve Casserly	Older Iowans Legislature
Specific questions about memory loss and other symptoms related to dementia should be added to assessment tools to more quickly identify individuals with Alzheimer's and related dementia and refer them to appropriate services.	Carol Sipfle	Alz. Assn.
Move beyond information and referral into determining financial and programmatic eligibility and authorizing of services.	Anthony Carroll	AARP
That Iowa encourage the use of electronic health records and the electronic collection of all information so that the transfer of information can be expedited and Iowans can be better served. The information needed for statistical data collection and evaluation is therefore readily accessible.	Bob Welsh	SLCU Consumer Member
That Iowa work to help change the institutional bias in Medicaid. Iowa should seek to influence national policies and make such changes as it can to help eliminate the institutional bias.	Bob Welsh	SLCU Consumer Member
Create a structure to ensure long-term coordination and accountability of the Single Point of Entry system.	Anthony Carroll	AARP
Sustain ADRC/SPE funding.	Anthony Carroll	AARP
Infrastructure with regards to staffing, system maintenance.	Berdette Ogden	Dept. of Public Health

That Iowa's single point of entry utilize "global budgeting" as is done in states such as Ohio, New Jersey, Oregon, Vermont and Washington.	Bob Welsh	SLCU Consumer Member
Seek protection of funding for SPE and other needed community-based senior services by collectively asking that the Senior Living Trust fund be restored to its original level, that it be made constitutionally protected and that the interest of this be used exclusively for home and community-based services. (While this proposal is not directly related to SPE, this relates to the funding for same and for the services needed by the client community.)	Eve Casserly	Older Iowans Legislature

Appendix B

House File 451 - Enrolled

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HOUSE FILE 451

AN ACT

RELATING TO A SINGLE POINT OF ENTRY LONG=TERM LIVING RESOURCES SYSTEM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. LEGISLATIVE FINDINGS == SINGLE POINT OF ENTRY LONG=TERM LIVING RESOURCES SYSTEM.

1. The general assembly finds that access to information regarding all components of the long=term living resources system is necessary to empower consumers in planning, evaluating, and making decisions to appropriately meet their individual long=term living needs. This access should be provided through a single point of entry into an integrated, seamless system that facilitates navigation of the variety of private and public resources available, minimizes service fragmentation, reduces duplication of administrative paperwork and procedures, enhances individual choice, supports informed decision making, and increases the cost=effectiveness of long=term living services and support systems.

2. a. A single point of entry long=term living resources system team is created, consisting of the following members:

(1) The director of the department of elder affairs, or the director's designee.

(2) The director of the department of human services, or the director's designee.

(3) The director of public health, or the director's designee.

(4) The director of the department of inspections and appeals, or the director's designee.

(5) The commissioner of insurance, or the commissioner's designee.

(6) The executive director of the Iowa finance authority, or the executive director's designee.

(7) The director of the department of veterans affairs, or the director's designee.

(8) The director of the department of workforce development, or the director's designee.

(9) A representative of the office of the governor.

(10) The director of an area agency on aging or the director's designee and a consumer member selected by the director.

(11) The state director of the AARP Iowa chapter or the state director's designee and a consumer member selected by the state director.

(12) The chairperson of the older Iowans legislature or the chairperson's designee and a consumer member selected by the chairperson.

(13) A consumer member of the senior living coordinating unit created in section 231.58 selected by the senior living coordinating unit.

(14) A representative of the Iowa hospital association.
(15) A representative of the Iowa pharmacy association.
(16) A representative of the Iowa health care association.
(17) A representative of the Iowa association of community providers.
(18) A representative of the Iowa association of homes and services for the aging.
(19) A representative of the Iowa association of home care.
(20) The director of the university of Iowa center on aging, or the director's designee.
(21) Two members of the senate and two members of the house of representatives, with not more than one member from each chamber being from the same political party.

b. The legislative members of the team shall serve in an ex officio, nonvoting capacity. The two senators shall be appointed by the president of the senate, after consultation with the leaders of the senate, and the two representatives shall be appointed by the speaker of the house, after consultation with the majority leader and the minority leader of the house of representatives.

c. Public members shall receive actual expenses incurred while serving in their official capacity and may also be eligible to receive compensation as provided in section 7E.6.

d. The team shall do all of the following:

(1) Hold at least four public meetings in at least four geographically balanced venues around the state to receive input regarding access to the long=term living resources system and recommendations for improved access. The team shall also receive input regarding the benefits of the use of electronic health records.

(2) Make recommendations regarding the structure of and best means of providing a single point of entry to the long=term living resources system. The team shall also make recommendations regarding the use of electronic health records.

(3) Submit a report of the team's findings from the meetings described in subparagraph (1) and the team's recommendations for establishing a single point of entry to the long=term living resources system to the general assembly on or before December 1, 2008. The recommendations may provide for multiple access sites that are standardized and coordinated to provide for access to the single point of entry, a management information system that links the resources available in order to provide a single electronic point of entry to the long=term living resources system, a telephonic single point of entry, or suggestions for colocation or integration of long=term living resources system administration and services. The report shall also include recommendations for funding the single point of entry to the long=term living resources system through available grants or other sources. The report shall also include recommendations regarding the use of electronic health records.

PATRICK J. MURPHY
Speaker of the House

JOHN P. KIBBIE
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 451, Eighty=second General Assembly.

MARK BRANDSGARD
Chief Clerk of the House

Approved _____, 2007

CHESTER J. CULVER
Governor

Appendix C

Fully Functioning Single Entry Point System/ADRC

These criteria were developed to assist states measure and assess their progress toward developing fully functioning Single Entry Point Systems/ADRCs. These criteria and recommended metrics are intended to be applicable across different types of ADRC models. Depending on the model of ADRC a state is implementing, the term "SEP/ADRC" may be interpreted to represent one operating organization in each community at the local level, a network of organizations serving as operating partners in each community at the local level, or a combination of state level and local level organizations operating in partnership. Metrics that should be interpreted or applied differently to systems with a "single entry point" than to systems where there are "multiple entry points" are noted.

Program Component	Criteria / Description	Recommended Metrics
Awareness and Information	*Public education; information on long-term support options.* • ADRCs serve as highly visible and trusted places where people can turn for the full range of long-term support options. • Actively promote public awareness of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.	• The SEP/ADRC has a proven **outreach and marketing plan** in place that takes into consideration: (a) culturally diverse, underserved and unserved populations, their family caregivers, and the professionals who serve them through focused outreach and community education; (b) the identification of unique needs of the different populations being served; (c) a strategy to assess the effectiveness of the outreach and marketing activities; and (d) a feedback loop to modify activities as needed. • The SEP/ADRC has a **comprehensive resource database** which includes information about the range of long term support options in the SEP/ADRC service area. Information regarding providers, programs, and services available in the SEP/ADRC service area (including for private-payment) is collected into a central database. - Resources included in the database conform to established Inclusion/Exclusion policies. - A system is in place for updating and ensuring the accuracy of the information provided. - The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities. - Statewide coverage for the database is preferable. • The SEP/ADRC may have a single or multiple entry points within the service area. All agencies operating entry points (operating partners) have access to the same comprehensive resource database and provide **consistent and uniform information.** • The SEP/ADRC actively markets to and serves **private pay** consumers in addition to those that require public assistance.

Program Component	Criteria / Description	Recommended Metrics
Assistance	*Long-term support options counseling; benefits counseling; employment options counseling; referral to other programs and benefits; crisis intervention; helping people to plan for their future long-term support needs.* • The ADRC will provide information and counseling to help people assess their potential need and eligibility for all available long-term support options, both public and private. • ADRC has the capacity to link consumers with needed support through appropriate referrals to other programs and benefits and has the ability to track client intake, needs assessment, and care plans. • ADRC has established collaborative relationships with programs that provide home and community-based services including SHIP, NFCSP, Alzheimer's Disease services, health promotion and disease prevention programs, transportation, employment, housing, adult education and others. • ADRC consistently conducts follow-up when needed to determine outcome of options counseling. • ADRC enables people to make informed, cost-effective decisions about long term care. • ADRC has process to ensure that people are connected to the appropriate crisis intervention services. • ADRC assists individuals to plan for future long-term care needs.	<u>Options Counseling</u> • SEP/ADRC has the capability, either through a single operating organization or through close coordination among operating partners, to provide accurate and comprehensive long term support options counseling to any consumer who requests it. • All SEP/ADRC entry point agencies use standard intake and screening instruments. • Protocols are in place to identify consumers who will be offered options counseling. At a minimum, this will include consumer that have gone through a comprehensive assessment process. • Options counseling sessions: (a) entail individualized assistance; (b) are provided in a uniform manner to all SEP/ADRC consumers with the use of protocols or standard operating procedures; and (c) are conducted by staff qualified to provide objective assistance to consumers in the process of making informed decisions, as evidenced by certification requirements and/or training/cross-training practices. • SEP/ADRC can demonstrate evidence that options counseling provided enables people to make informed, cost-effective decisions about long-term care services. • SEP/ADRC uses systematic processes across all entry points to provide information, referral and access to services. These services include, at a minimum: - Public benefits (OAA, Medicaid, Medicare including new Medicare Modernization Act benefits, state revenue programs and others) - Employment - Health promotion/disease prevention - Transportation - Crisis/Emergency services - Services for family caregivers - Residential care including assisted living <u>Referrals and Follow Up</u> • SEP/ADRC has the ability to track referrals made. • SEP/ADRC consistently conducts follow-up to determine outcome of options counseling. <u>Crisis Intervention</u> • SEP/ADRC responds to situations requiring short-term assistance to support an individual until a plan for long-term support services is in place. • Short-term case management is available as needed for all target populations and provided directly by SEP/ADRC (by at least one operating partner in multiple entry point systems), or is contracted out. <u>Future Long Term Support Needs Planning</u> • Evidence of one of the following: (1) SEP/ADRC is involved with Own Your Own Future Campaign; (2) SEP/ADRC is a pilot Home Equity Conversion Mortgage counseling site; or (3) SEP/ADRC provides futures planning directly or contractually by staff who possess specific skills related to LTC needs planning and financial counseling.
Access	*Eligibility screening; assistance in*	• SEP/ADRC has a single, standardized entry process for accessing

Program Component	Criteria / Description	Recommended Metrics
	gaining access to private-pay long-term support services; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination that is integrated or closely coordinated with the Resource Center services; one-stop access to all public programs for community and institutional long-term support services. • ADRC serves as the entry point to publicly funded long term care. • The ADRC has in place necessary protocols and procedures to facilitate access (intake, eligibility, assessment) to public programs that is integrated or so closely coordinated that the process is seamless for consumers. • ADRC support helps to reduce the cost of long term care by delaying or preventing the need for more expensive public long term care services.	public and private services. In multiple entry point systems, the entry process is coordinated and standardized so that consumers experience the same process wherever they enter the system. • For SEP/ADRCs with multiple entry points, the entry processes are overseen by a coordinating entity. • Financial and functional eligibility determination processes are highly coordinated. • SEP/ADRC uses uniform criteria across sites to assess risk of institutional placement in order to target support to individuals at high-risk. • SEP/ADRC staff conduct level of care assessments that are used for determining functional eligibility, or SEP/ADRC has a formal process in place for seamlessly referring consumers to the agency that conducts level of care assessments. • ADRC/SEP staff assist consumers as needed with initial processing functions (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews. 42 CFR 435.904). • Staff located on-site within the ADRC/SEP can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC/SEP staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of consumers. • SEP/ADRC is able to track individual consumers' eligibility status throughout the process of eligibility determination and redetermination. • In localities where waiting lists for public LTC programs or services exist, there is a process by which the SEP/ADRC is informed of consumers who are on the waiting list and the SEP/ADRC conducts follow-up with those individuals. • There is a process by which the SEP/ADRC is informed of consumers who are determined ineligible for public LTC programs or services and the SEP/ADRC conducts follow-up with those individuals. • SEP/ADRC has a plan for reducing the average time from first contact to eligibility determination and the average time is below current time requirement. • There is a reduction in the rate of institutional placement in the SEP/ADRC service area. • SEP/ADRC tracks diversions and transitions (i.e., # nursing home diversions attempted and # of successful diversions; # nursing home relocations to community completed). • SEP/ADRC can report the proportion of consumers requesting services that actually receive them. • SEP/ADRC has a plan for streamlining access to long-term care signed by the State Medicaid Agency, State Unit on Aging and the State agency(s) representing target population(s) of people with disabilities. (Streamlining Access Plan).

Program Component	Criteria / Description	Recommended Metrics
Target Populations	*ADRCs must serve the elderly and at least one **target population** of people with disabilities (e.g. physical; developmental/mental retardation; mental illness). ADRC projects should move towards the goal of serving persons with disabilities of all ages and types.*	• The SEP/ADRC tracks the number of actual individuals served against the resident population estimate, by target population. • SEP/ADRC demonstrates competencies relating to serving all of its target populations. • SEP/ADRC is accessible to all of the populations it serves. • There is evidence that the SEP/ADRC is moving towards the goal of serving all persons with disabilities, either through a single operating organization or through close coordination among operating partners.
Critical Pathways to Long Term Support	*ADRCs will create formal linkages between and among the **critical pathways to long-term support.***	• SEP/ADRC has "formal linkages" that involve all three of the following components that are updated on an ongoing basis: (1) providing training and education about the SEP/ADRC to critical pathway providers (CPPs); (2) involving CPPs in advisory board representation; and (3) establishing protocols for referrals, particularly with hospitals and LTC facilities.
Partnerships & Stakeholder Involvement	*ADRCs must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving the target populations(s) of people with disabilities.* *ADRCs must establish strong partnerships with the **State Health Insurance Assistance Program (SHIP**) and other programs instrumental to ADRC activities. Examples of other programs include Alzheimer's disease programs, Area Agencies on Aging, Centers for Independent Living, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers and other community-based organizations.* *ADRCs must **meaningfully involve stakeholders, including consumers**, in planning, implementation and evaluation activities.*	<u>Medicaid</u> • SEP/ADRC has an agreement with Medicaid agency to ensure that access to Medicaid benefits is as streamlined as possible for consumers; MOU describes explicit role of each agency and information sharing policies. <u>Aging or Disability Partners</u> • There is evidence of collaboration, including formal agreements, at the state and pilot level between aging and disability partners. • SEP/ADRC has protocols for information sharing and cross-training across entry point operating partners and with other critical aging and disability services partners in the community. <u>Stakeholders</u> • If the SEP/ADRC and SHIP are operated by separate entities, there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals. • There is evidence of strong collaboration with programs and services instrumental to SEP/ADRC activities including home and community-based service providers, residential care alternatives including assisted living, institutional care providers, hospitals and other critical pathways and others. <u>Consumers</u> • Formal mechanisms for consumer involvement have been established, including consumer representation on the state/local SEP/ADRC advisory board or governing committee and there is evidence that consumers have been involved in planning, implementation and evaluation activities.

Program Component	Criteria / Description	Recommended Metrics
IT/MIS	*The ADRC program must have a **management information system** that supports the functions of the program including tracking client intake, needs assessment, care plans, utilization and costs.*	• SEP/ADRC uses a management information system that can support the program functions. • SEP/ADRC can submit evidence of reports on the following: - # of unduplicated consumers YTD - Referrals for current month, referring agency/entity, # referrals under age 60; # referrals age 60 and older. o Types of assistance provided o Timing of eligibility determinations o Information regarding level of impairment and preferred support need o Disposition/placements (e.g., waiver, institution) • SEP/ADRC has established an efficient process for sharing information electronically with external entities, as needed, from intake to service delivery. In multiple entry point systems, all entry points use MIS that allows for electronic exchange of resource and client data across entry points and with other partners, as appropriate.
Evaluation Activities	*At a minimum, ADRCs must have **performance goals and indicators** related to visibility, trust, ease of access, responsiveness, efficiency and effectiveness.*	• SEP/ADRC is measuring performance related to the established indicators. • SEP/ADRC can demonstrate ability to develop reports summarizing issues and making recommendations for corrective action or quality improvement based on performance indicators. • SEP/ADRC has used information obtained from consumer satisfaction evaluations to improve performance. • SEP/ADRC can demonstrate ability to document the impact on nursing home use • SEP/ADRC can demonstrate the ability to document the impact on the use of home and community based services. • SEP/ADRC can demonstrate a reduction in the average time from first contact to eligibility determination for publicly funded home and community-based services. • SEP/ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances. • SEP/ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered.
Staffing and Resources	• Capacity • Quality • Any conflicts of interest have been addressed • Specialized training/gaps identified • Private and public funding opportunities are pursued to create sustainable programs	• SEP/ADRC has adequate capacity to assist consumers in a timely manner with long term support requests and referrals, including referrals from critical pathway providers. • SEP/ADRC has an individual assigned to be the overall director/manager/coordinator of all SEP/ADRC operations. It is particularly important to have an overall coordinator or manager with sufficient authority to maintain quality processes when SEP/ADRC functions occur in more than one location or agency. • SEP/ADRC has conducted an assessment of potential funding sources such as Medicaid Federal Financial Participation, foundations and community organizations.

Appendix D

Iowa: Progress towards a Fully Functioning Single Entry Point System/ADRC

March 2008

This document presents The Lewin Group's assessment of the progress that Iowa has made toward realizing the AoA/CMS vision of a fully functioning ADRC. In the first three columns, the ADRC program components, their descriptions, and recommended metrics describe the fully functional ADRC vision. The description of ADRC Grantee Progress in the fourth column identifies grantee strengths as well as areas for future growth. In the last column are suggested Technical Assistance Resources that relate to the different Program Components and/or were discussed on the Fully Functioning call that AoA and The Lewin Group held with Iowa on March 3, 2008.

Major ADRC strengths – 1) Collaboration across aging, PD and DD communities; 2) statewide resource databases; and 3) state leadership and SEP legislation

Most important areas for growth – 1) coordinating ADRC activities with state plan for SEP system; 2) streamlining access at local levels; and 3) piloting options counseling and streamlined processes at local level

"At a Glance" Rating System:

● = Meets Criteria ◐ = Partially Meets Criteria/ Making Progress ○ = Important Area for Growth

Program Component	Criteria / Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
Awareness & Information	*Public education; information on long-term support options.* • ADRCs serve as highly visible and trusted places where people can turn for the full range of long-term support options • Actively promote public awareness of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.	• The SEP/ADRC has a proven **outreach and marketing plan** in place that takes into consideration: (a) culturally diverse, underserved and unserved populations, their family caregivers, and the professionals who serve them through focused outreach and community education; (b) the identification of unique needs of the different populations being served; (c) a strategy to assess the effectiveness of the outreach and marketing activities; and (d) a feedback loop to modify activities as needed. • The SEP/ADRC has a **comprehensive resource database** which includes information about the range of long term support options in the SEP/ADRC service area. Information regarding providers, programs, and services available in the SEP/ADRC service area (including for private-payment) is collected into a central database.	**Outreach and Marketing** ◐ Iowa has implemented a statewide marketing plan for LifeLongLinks (LLL). The new pilot sites will have an opportunity to do more public education locally about community based options for LTC. **Resource Database** ● Iowa has three comprehensive statewide resource databases connected through LifeLongLinks website. Each database uses inclusion/exclusion criteria and are routinely updated and maintained. They think that LifeLongLinks is becoming more known. The SEP Resource Committee is interested in LLL being the key tool for information and awareness in the new SEP system. They would like to see more development similar to Network of Care or Minnesota's site, so that it is more interactive. Iowa and Nebraska AIRS are now collaborating on I&R for all ages and populations, which is a	ADRC-TAE Issue Brief - Marketing to External Audiences: http://www.adrc-tae.org/tiki-download_file.php?fileId=2833 ADRC-TAE Training Handout - Social Marketing Topic Overview: http://www.adrc-tae.org/tiki-download_file.php?fileId=26863 ADRC-TAE Issue Brief - Private Industry Lessons: Branding and Marketing: http://www.adrc-tae.org/tiki-download_file.php?fileId=26301

● = Meets Criteria ◍ = Partially Meets Criteria/ Making Progress ○ = Important Area for Growth

Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
		- Resources included in the database conform to established Inclusion/Exclusion policies. - A system is in place for updating and ensuring the accuracy of the information provided. - The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities. - Statewide coverage for the database is preferable. • The SEP/ADRC may have a single or multiple entry points within the service area. All agencies operating entry points (operating partners) have access to the same comprehensive resource database and provide **consistent and uniform information.** • The SEP/ADRC actively markets to and serves **private pay** consumers in addition to those that require public assistance.	success and a sign of progress. They are talking about referral protocols and developing a common taxonomy. **Private Pay** ◍ There is some content on LifeLongLinks targeted toward private paying families and related to futures planning. The task force has not really talked about this or focused on this area yet, but they will need to. **Suggestion**: State should consider increasing its focus and helping ADRCs increase focus on actively reaching out to private pay consumers. Raising visibility and awareness about LTC options among private paying populations is a key element of the ADRC initiative, and it is also an important way to build a broader base of public support for the initiative.	The Community Toolbox (University of Kansas): Successful Marketing and Institutionalization of the Initiative: http://ctb.ku.edu/en/tablecontents/chapter_1045.htm Minnesota's Approach to Data Maintenance Presentation: http://www.adrc-tae.org/tiki-download_file.php?fileId=27032 Setting Inclusion/Exclusion Criteria: Determining the Scope of a Resource File: http://www.nasua.org/informationandreferral/pdf/inclusion_exclusion.pdf ADRC-TAE Training Handout - Marketing to and Serving Private Paying Populations: http://www.adrc-tae.org/tiki-download_file.php?fileId=27297
Assistance	*Long-term support options counseling; benefits counseling; employment options counseling; referral to other programs and benefits; crisis intervention; helping people to plan for their future long-term support needs.* • The ADRC will provide information and counseling to help people assess their potential need and eligibility for	Options Counseling • SEP/ADRC has the capability, either through a single operating organization or through close coordination among operating partners, to provide accurate and comprehensive long term support options counseling to any consumer who requests it. • All SEP/ADRC entry point agencies use standard intake and screening instruments.	**General Comments:** Most of the services in this section have not yet been offered in-person or by telephone through the ADRC in Iowa, except to the extent that the partnering networks already provide these services to their own target populations at the local level. Iowa will fund two local pilot programs in spring/early summer to design and implement options counseling as well as standard intake and referral procedures.	ADRC-TAE Issue Brief - Long Term Support Options Counseling: Decision Support in ADRCs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26557

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
	all available long-term support options, both public and private. • ADRC has the capacity to link consumers with needed support through appropriate referrals to other programs and benefits and has the ability to track client intake, needs assessment, and care plans. • ADRC has established collaborative relationships with programs that provide home and community-based services including SHIP, NFCSP, Alzheimer's Disease services, health promotion and disease prevention programs, transportation, employment, housing, adult education and others. • ADRC consistently conducts follow-up when needed to determine outcome of options counseling. • ADRC enables people to make informed, cost-effective decisions about long term care. • ADRC has process to ensure that people are connected to the appropriate crisis intervention services. • ADRC assists individuals to plan for future long-term care needs.	• Protocols are in place to identify consumers who will be offered options counseling. At a minimum, this will include consumers who have gone through a comprehensive assessment process. • Options counseling sessions: (a) entail individualized assistance; (b) are provided in a uniform manner to all SEP/ADRC consumers with the use of protocols or standard operating procedures; and (c) are conducted by staff qualified to provide objective assistance to consumers in the process of making informed decisions, as evidenced by certification requirements and/or training/cross-training practices. • SEP/ADRC can demonstrate evidence that options counseling provided enables people to make informed, cost-effective decisions about long-term care services. <u>Information and Referral</u> • SEP/ADRC uses systematic processes across all entry points to provide information, referral and access to services. These services include, at a minimum: - Public benefits (OAA, Medicaid, Medicare including new Medicare Modernization Act benefits, state revenue programs and others) - Employment - Health promotion/disease prevention - Transportation - Crisis/Emergency services - Services for family caregivers - Residential care including assisted living	**Options Counseling** ○ Iowa will begin piloting options counseling services through local level pilot sites. They expect that a system, standards and protocols for options counseling will be designed and implemented by the local level networks of organizations chosen as pilot sites. **Information and Referral** ◍ In terms of I&R, Iowa has information and resources on all types of resources listed and includes them in LLL at the state level. The extent to which they will be able to provide comprehensive I&R in all areas listed at the local level will depend on pilot sites that are selected and partnerships developed. **Referrals and Follow Up** ○ Iowa's new pilots will need to examine and adjust their existing referral protocols between and among partners as well as identify a way to follow up with consumers on a routine basis. **Suggestion**: Following up with consumers to make sure they connect with needed services is a key function of the ADRC. Consider testing a standard under which staff follow-up by telephone with a set percentage of callers (perhaps 30% at first) to track the appropriateness of services and ensure that consumers are able to make the necessary connections. The data collected during follow-up can be used to identify service gaps in the community. Staff can share follow-up results with one another as a way of improving ADRC service delivery. **Crisis Intervention** ◍ Iowa's Department of Elderly Affairs administers the Elder Abuse program through AAAs, which will be involved in new pilot sites. **Suggestion**: Involve community partners in discussion of how to provide and coordinate short term case management to consumers entering the system in different areas.	ADRC-TAE Training Handout - Options Counseling Overview: http://www.adrc-tae.org/tiki-download_file.php?fileId=26845 Wisconsin's Options Counseling Toolkit: http://www.adrc-tae.org/tiki-index.php?page=LTCOptionsToolkit Indiana Standard Operating Procedures Manual http://www.adrc-tae.org/tiki-download_file.php?fileId=27255 ADRC-TAE Tool - Measuring Options Counseling: Goals and Objectives Grid: http://www.adrc-tae.org/tiki-index.php?page=PreviousEvaluationPeerWorkGroupCalls Intake and screening tools from Ohio and North Carolina as well as other ADRCs: http://www.adrc-tae.org/tiki-index.php?page=p_Intake New Jersey Automated Screen for Community Services http://www.adrc-tae.org/tiki-download_file.php?fileId=2604

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
		Referrals and Follow Up • SEP/ADRC has the ability to track referrals made. • SEP/ADRC consistently conducts follow-up to determine outcome of options counseling. Crisis Intervention • SEP/ADRC responds to situations requiring short-term assistance to support an individual until a plan for long-term support services is in place. • Short-term case management is available as needed for all target populations and provided directly by SEP/ADRC (by at least one operating partner in multiple entry point systems), or is contracted out. Future Long Term Support Needs Planning • Evidence of one of the following: (1) SEP/ADRC is involved with Own Your Future Campaign; (2) SEP/ADRC is a pilot Home Equity Conversion Mortgage counseling site; or (3) SEP/ADRC provides futures planning directly or contractually by staff who possess specific skills related to LTC needs planning and financial counseling.	○ **Future Long Term Support Needs Planning** Assisting consumers to plan for their future long term care needs will be part of options counseling in the new pilots. **Suggestion**: The state should support and encourage sites to build expertise and resources in this area. This might involve training some staff at each site to become counselors, identifying community partners who can routinely provide this service for ADRC consumers, and/or developing off-the-shelf informational materials and tools such as Wisconsin's resource called House in Order. The state may be able to reach more private paying consumers by adding an informational section about planning for long term care needs into the LifeLongLinks website.	NASUA Vision 2010: Toward a Comprehensive Aging Information Resource System for the 21st Century: http://www.nashp.org/Files/NASUA_Vision.pdf NCOA Use Your Home to Stay at Home Program: http://www.ncoa.org/content.cfm?sectionid=250 A House in Order: How Planning for Your Aging Brings Peace of Mind: http://www.adrc-tae.org/tiki-download_file.php?fileId=26901 American Institute of Certified Public Accountants (AICPA) http://www.feedthepig.org/AboutUs.aspx Own Your Future Campaign Information http://www.aoa.gov/LTC/404/404_message.htm
Access	*Eligibility screening; assistance in gaining access to private-pay long-term support services; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination that is integrated or closely coordinated with the Resource Center services; one-stop access to all public programs for community and institutional long-term support services.*	• SEP/ADRC has a single, standardized entry process for accessing public and private services. In multiple entry point systems, the entry process is coordinated and standardized so that consumers experience the same process wherever they enter the system. • For SEP/ADRCs with multiple entry points, the entry processes are overseen by a coordinating entity. • Financial and functional eligibility determination processes are highly coordinated.	○ **General Comments:** Iowa's ADRC project has not yet focused on streamlining the eligibility processes for Medicaid and other public programs. They have focused on building partnerships with Medicaid, Aging and Disability agencies, which should put them in a strong position once their local pilot sites begin operations. ADRC staff are also staffing the SEP Resource Committee that will make recommendations to legislature about developing a SEP system. When recommendations are made, big changes could follow quickly. ADRC staff should work to ensure pilot sites are positioned to implement these changes.	ADRC-TAE Issue Brief - Engaging Medicaid Agencies About ADRCs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26974 ADRC-TAE Tool - Streamlining Access Self-Assessment and Workbook with State Examples – Hoops: http://www.adrc-tae.org/tiki-download_file.php?fileId=27057

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
	• ADRC serves as the entry point to publicly funded long term care. • The ADRC has in place necessary protocols and procedures to facilitate access (intake, eligibility, assessment) to public programs that is integrated or so closely coordinated that the process is seamless for consumers. • ADRC support helps to reduce the cost of long term care by delaying or preventing the need for more expensive public long term care services	• SEP/ADRC uses uniform criteria across sites to assess risk of institutional placement in order to target support to individuals at high-risk. • SEP/ADRC staff conduct level of care assessments that are used for determining functional eligibility, or SEP/ADRC has a formal process in place for seamlessly referring consumers to the agency that conducts level of care assessments. • ADRC/SEP staff assist consumers as needed with initial processing functions (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews. 42 CFR 435.904). • Staff located on-site within the ADRC/SEP can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC/SEP staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of consumers. • SEP/ADRC is able to track individual consumers' eligibility status throughout the process of eligibility determination and redetermination. • In localities where waiting lists for public LTC programs or services exist, there is a process by which the SEP/ADRC is informed of consumers who are on the waiting list and the SEP/ADRC conducts follow-up with those individuals. • There is a process by which the SEP/ADRC is informed of consumers who are determined ineligible for	ADRC should also advocate for system changes to include disability service systems as well as aging. **Suggestion**: In implementing pilots, ADRC staff should keep in mind the importance of tracking diversions, transitions and placement as a way to demonstrate impact of options counseling and SEP system.	ADRC-TAE Issue Brief - Options for Assessing the Impact of ADRCs on Long Term Care Costs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26986 ADRC-TAE Issue Brief - ADRC Roles in Diversion: http://www.adrc-tae.org/tiki-download_file.php?fileId=2805

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
		public LTC programs or services and the SEP/ADRC conducts follow-up with those individuals. • SEP/ADRC has a plan for reducing the average time from first contact to eligibility determination and the average time is below current time requirement. • There is a reduction in the rate of institutional placement in the SEP/ADRC service area. • SEP/ADRC tracks diversions and transitions (i.e., # nursing home diversions attempted and # of successful diversions; # nursing home relocations to community completed). • SEP/ADRC can report the proportion of consumers requesting services that actually receive them. • SEP/ADRC has a plan for streamlining access to long-term care signed by the State Medicaid Agency, State Unit on Aging and the State agency(s) representing target population(s) of people with disabilities. (Streamlining Access Plan).		
Target Populations	*Resource Center grantees must serve the elderly and at least one **target population** of people with disabilities (e.g. physical; developmental/mental retardation; mental illness). ADRC projects should move towards the goal of serving persons with disabilities of all ages and types.*	• The SEP/ADRC tracks the number of actual individuals served against the resident population estimate, by target population. • SEP/ADRC demonstrates competencies relating to serving all of its target populations. • SEP/ADRC is accessible to all of the populations it serves. • There is evidence that the SEP/ADRC is moving towards the goal of serving all persons with disabilities, either through a single operating organization or through close coordination among operating partners.	● At the state level, ADRC partners represent full range of disability populations and are committed to serving all disability types. The state advisory board should be able to guide and monitor the pilot sites' activities to ensure pilot sites are competent and accessible to all populations. ◍ The original SEP legislation calling for the SEP Resource Committee did not specifically include all disability populations, and it seems the legislative intent was for it to focus primarily on streamlining aging services. Disability advocates have been attending the meetings and they do have one advocate for including them in the SEP system on the legislatively appointed Resource Committee. **Suggestion**: Iowa should draw on the expertise of its ADRC advisory board, as well	ADRC-TAE Issue Brief - Supporting Adults with Physical Disabilities: http://www.adrc-tae.org/tiki-download_file.php?fileId=2823 ADRC-TAE Issue Brief - Long Term Support for Individuals with Mental Retardation/Developmental Disabilities: http://www.adrc-tae.org/tiki-download_file.php?fileId=2827

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
			as the experience of other states, to advise the SEP Resource Committee about including all populations in SEP planning process – even if initially they will focus on streamlining aging services and incorporate other systems later. Aging and disability system integration and/or coordination is a major national trend. The experience of other states highlights the importance of involving all groups in the planning and discussion up front and early. This is important as a way for building broad-based support for the initiative, as well as to make sure the SEP design will be compatible with other service systems when they are eventually integrated.	Resource in development: ADRC-TAE Issue Brief - Serving Individuals with Mental Illness
Critical Pathways to Long Term Support	*Resource Centers will create formal linkages between and among the **critical pathways to long-term support.***	• SEP/ADRC has "formal linkages" that involve all three of the following components that are updated on an ongoing basis: (1) providing training and education about the SEP/ADRC to critical pathway providers (CPPs); (2) involving CPPs in advisory board representation; and (3) establishing protocols for referrals, particularly with hospitals and LTC facilities.	◐ At state level, ADRC has worked to reach out to different associations. With their continuation funding, they are adding to LLL website more information for and a special section for hospital discharge planners. They tried to get a good group of critical pathway providers for the local advisory groups. They did not mandate which ones should be involved. They think it will be an on-going conversation. **Suggestion**: Reaching out to and actively intervening in critical pathways can be a key streamlining access strategy. On average across states, CPPs account for more than 50% of all referrals to ADRCs. Consider how ADRCs can more formally intervene in critical pathways, through some kind of state mandate or partnership. For example, Arkansas recently passed legislation requiring anyone entering a nursing home to receive ADRC options counseling. Other states have developed less formal linkages through partnerships and referral protocols.	ADRC-TAE Issue Brief - Hospital-Based Nursing Facility Diversion Initiatives: http://www.adrc-tae.org/tiki-download_file.php?fileId=27079 New Hampshire protocols for discharge planners referring to ADRC: http://www.adrc-tae.org/tiki-searchresults.php?words=nh+protocols+for+discharge+planners&where=pages An Act to Create the Arkansas Options Counseling for Long Term Care Program: http://www.arkleg.state.ar.us/ftproot/bills/2007/public/HB1132.pdf

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
Partnerships & Stakeholder Involvement	*ADRC's must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving the target populations(s) of people with disabilities.* *Resource Centers must establish strong partnerships with the* ***State Health Insurance Assistance Program (SHIP****) and other programs instrumental to ADRC activities. Examples of other programs include Alzheimer's disease programs, Area Agencies on Aging, Centers for Independent Living, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers and other community-based organizations.* *Resource Center programs must* ***meaningfully involve stakeholders, including consumers****, in planning, implementation and evaluation activities.*	Medicaid • SEP/ADRC has an agreement with Medicaid agency to ensure that access to Medicaid benefits is as streamlined as possible for consumers; MOU describes explicit role of each agency and information sharing policies. Aging and Disability Partners • There is evidence of collaboration, including formal agreements, at the state and pilot level between aging and disability partners. • SEP/ADRC has protocols for information sharing and cross-training across entry point operating partners and with other critical aging and disability services partners in the community. Stakeholders • If the SEP/ADRC and SHIP are operated by separate entities, there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals. • There is evidence of strong collaboration with programs and services instrumental to SEP/ADRC activities including home and community-based service providers, residential care alternatives including assisted living, institutional care providers, hospitals and other critical pathways and others. Consumers • Formal mechanisms for consumer involvement have been established, including consumer representation on the state/local SEP/ADRC advisory board or governing committee and there is evidence that consumers have been involved in planning, implementation and evaluation activities.	Medicaid ◍ Medicaid staff have been active and consistent participants in ADRC at state level, assisted in developing RFP for new ADRC pilot sites, and just completed a MOU. However, they will need to increase the level of engagement with Medicaid as they move forward with the pilot sites and SEP development. **Suggestion**: Use the pilot sites as an opportunity to renew interest in the ADRC within Medicaid. Identify additional staff/point people within Medicaid to ensure more consistent involvement. Make the case that streamlining changes that are piloted through the new ADRC sites may be part of SEP Resource Committee's recommendations to legislature, so Medicaid should be involved in the pilot site's streamlining plans. Aging and Disability Partner ● Strong partnerships at state level. RFP for new pilot sites put heavy emphasis on partnerships at local level. Stakeholders and Consumers ◍ SHIP is in Dept of Insurance and representative from this department serves on Advisory Board. In the aging network, they do have a good connection with SHIP, but not as sure about disability community. **Suggestion**: Disability partners may be able to help spread the word to consumers about SHIP services being available to people under 60 with disabilities. ● Consumers participate on advisory board at state level and will do so on local levels. ADRC has administered consumer satisfaction surveys statewide.	ADRC-TAE Issue Brief - Engaging Medicaid Agencies About ADRCs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26974 ADRC-TAE Issue Brief - Strategies for Building Collaboration http://www.adrc-tae.org/tiki-download_file.php?fileId=2821 ADRC-TAE Issue Brief - Public and Private Partnerships: http://www.adrc-tae.org/tiki-download_file.php?fileId=2813 ADRC-TAE Issue Brief - Facilitating a Productive Advisory Committee: http://www.adrc-tae.org/tiki-download_file.php?fileId=2825

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
IT/MIS	*The ADRC program will have a **management information system** that supports the functions of the program including tracking client intake, needs assessment, care plans, utilization and costs.*	• SEP/ADRC uses a management information system that can support the program functions. • SEP/ADRC can submit evidence of reports on the following: - # of unduplicated consumers YTD - Referrals for current month, referring agency/entity, # referrals under age 60; # referrals age 60 and older. o Types of assistance provided o Timing of eligibility determinations o Information regarding level of impairment and preferred support need o Disposition/placements (ex. waiver, institution) • SEP/ADRC has established an efficient process for sharing information electronically with external entities, as needed, from intake to service delivery. In multiple entry point systems, all entry points use MIS that allows for electronic exchange of resource and client data across entry points and with other partners, as appropriate.	◍ AAAs all use ESP for I&R and client tracking; other potential partnering organizations use other client tracking systems. MIS is under discussion right now in the aging network. The AAAs may move to software that it would be easier to use AIRS taxonomy. **Suggestion**: State should encourage aging network to plan for and build capacity to share data with organizations outside the network, as this will be a requirement for ADRCs and is a significant trend in IT. State should also work with new pilot sites to facilitate data sharing and ensure consistent and standardized data collection and reporting.	Moving Forward: Opportunities for IT Advances in the Aging Network: http://www.adrc-tae.org/tiki-download_file.php?fileId=26984 Improving HCBS Delivery Systems for Older Adults and Individuals with Disabilities: Redesigning Information Technology and Business Processes to Support Participant Control, Quality, and Cost Effectiveness: http://www.adrc-tae.org/tiki-download_file.php?fileId=27215 Review of IT Systems for Single Point of Entry: http://www.adrc-tae.org/tiki-download_file.php?fileId=1700 ADRC-TAE Tool - ADRC MIS Requirements Development Tool: http://www.adrc-tae.org/tiki-download_file.php?fileId=396
Evaluation Activities	*At a minimum, ADRCs must have **performance goals and indicators** related to visibility, trust, ease of access, responsiveness, efficiency and effectiveness.*	• SEP/ADRC is measuring performance related to the established indicators. • SEP/ADRC can demonstrate ability to develop reports summarizing issues and making recommendations for corrective action or quality improvement based on performance indicators. • SEP/ADRC has used	● ADRC has benefited from strong evaluation team and it will continue through pilot. The new sites will have to cooperate with IA State evaluators, which they hope will mean full access to staff, data and budget information. The IA State evaluators will continue to handle the survey work. **Suggestion**: Partnering organizations may have different levels of capacity or quality assurance. Use consumer satisfaction survey process as a way to help pilot sites build capacity for ongoing data	ADRC State Project Evaluation Guidelines for Assessing ADRC Project Progress and Accomplishments: http://www.adrc-tae.org/tiki-download_file.php?fileId=1671

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
		information obtained from consumer satisfaction evaluations to improve performance. • SEP/ADRC can demonstrate ability to document the impact on nursing home use • SEP/ADRC can demonstrate the ability to document the impact on the use of home and community based services. • SEP/ADRC can demonstrate a reduction in the average time from first contact to eligibility determination for publicly funded home and community-based services. • SEP/ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances. • SEP/ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered.	collection and quality assurance activities. ◍ In implementing pilots, ADRC should keep in mind the importance of quality assurance across all partners – which can be particularly difficult in decentralized models – as well as measuring outcomes of options counseling, tracking diversions, transitions and placement. **Suggestion**: Put evaluation and data collection issues on agenda to discuss with Medicaid. It may spark some interest if they see the potential for cost-savings and will also provide an opening to talk more about data sharing and looping the ADRC into the eligibility determination process.	ADRC-TAE Tool - Selected Measures of Streamlining Access: http://www.adrc-tae.org/tiki-download_file.php?fileId=2493 ADRC-TAE Issue Brief – Excellent Customer Service in an ADRC: http://www.adrc-tae.org/tiki-download_file.php?fileId=2839 Wisconsin ADRC Quality Site Review Process: http://www.nashp.org/Files/WI_ADRC_Site_Quality_Review.doc ADRC-TAE Issue Brief - Options for Assessing the Impact of ADRCs on Long Term Care Costs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26986
Staffing and Resources	• Capacity • Quality • Any conflicts of interest have been addressed • Specialized training/gaps identified • Private and public funding opportunities are pursued to create sustainable programs.	• SEP/ADRC has adequate capacity to assist consumers in a timely manner with long term support requests and referrals, including referrals from critical pathway providers. • SEP/ADRC has an individual assigned to be the overall director/manager/coordinator of all SEP/ADRC operations. It is particularly important to have an overall coordinator or manager with sufficient authority to maintain quality processes when SEP/ADRC functions occur in more than one location or agency.	○ Adequacy of staffing and resources at local level will be determined when pilot sites are selected. ● State leadership of ADRC is strong, has a clear vision for ADRC growth and development, and is working closely with SEP Resource Committee on its vision for statewide SEP system. ◍ SUA recently began claiming for case management services. There may be opportunity for legislative funding, depending on recommendations of SEP Resource Committee. Current House and Senate study bills discuss ADRC (continuing funding) and they are part of LTC legislation. One legislative author is on the SEP Resource Committee. Suggestion: Explore FL and MT strategies for	ADRC-TAE Training Handout - Sustainability Topic Overview: http://www.adrc-tae.org/tiki-download_file.php?fileId=26841 ADRC Profiles in Sustainability: http://www.adrc-tae.org/tiki-download_file.php?fileId=26355 ADRC Business Plan Template http://www.adrc-tae.org/tiki-download_file.php?fileId=2846

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
		• SEP/ADRC has conducted an assessment of potential funding sources such as Medicaid Federal Financial Participation, foundations and community organizations.	claiming FFP. FL is claiming for employees who are 100% dedicated to Medicaid and they are also testing Wisconsin's 100% time reporting form in their AAAs to see how cumbersome this process would be for them. If IA wants to pursue the cost/benefit of potential claiming, ADRC-TAE is available for consult.	Information on Medicaid funding is available at: http://www.adrc-tae.org/tiki-index.php?page=MedicaidFunding Resources from Montana, Florida, Wisconsin and other states on working with Medicaid on FFP http://www.adrc-tae.org/tiki-index.php?page=Medicaid

Appendix D

SPERT "Other States" Report

SPERT "Other States" Report

(As Compiled by Anthony Carroll, AARP Iowa ASD Advocacy)

Oregon, Nevada, Nebraska, Illinois, Maryland, New Jersey & Minnesota

July 14, 2008

1

Caveats

- Quick and Dirty Snapshots of States, not comprehensive analysis (except where otherwise attached or referenced)
- Remember these are subjective, impressions. Survey often called for opinions. Even when multiple sources consulted, still opinions.
- Not meant to be authoritative, comprehensive.

2

Common Themes

- Humbleness about what these states have done, and what they have yet do.
  - Many: "Well I'm not sure we've gone as far as everyone hoped." OR "Wish we had more to report."
  - Balanced with not wanting to be overly critical.
- Common theme that this is ongoing, takes continuing commitment, and evolving
- **FUNDING!!!!!!!**

3

Overview of Process

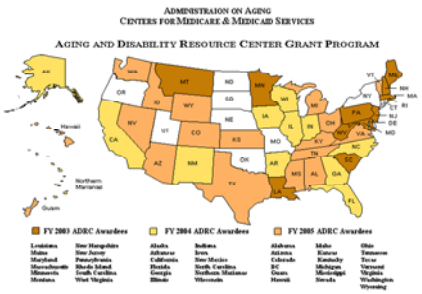
- Started with AARP state offices. In most cases several people consulted.
- State agencies were used either as sources for information, and in some cases have their own survey results
- Questions were answered in different ways, and to varying degrees of depth

4

Overview of States

5

ADRC Awardees



6

Oregon (Background stats)

- Oregon has had one of the lowest % institutionalization for some time, and has consistently had THE highest % of the LTC spending on HCBS (70+%).
- Their state budget is set up to allow them to shift Medicaid NF $ from NF to HCBS (have a received a waiver to do so).

7

Oregon Background

- *Oregon started looking at access to LTC and state spending on HCBS in 1970's. In 1979, Don's district was part of a demonstration project evaluated and used in the 1981 legislation. His AAA was one picked because they were already starting in that direction.*
- *In 1981, legislature passed law. Experiment in seeing if Oregon could: better serve people in community v. nursing facilities.*
- *Gave local AAA's the option to stay focus on traditional AAA duties or take on this role of being the entry points for LTC. The key here: **optional**, **local points** of entry. Don estimates about ??80% of population served this way, but some rural AAA's have not opted to participate.*
- OR really does not have a viable SPE system as you would define. OR did NOT receive AoA $ for ADRCs and is playing catch up

8

Oregon Partners

- *Labor & senior activists, AAA's advocating for some time. Worked with nursing facilities too from beginning*

9

Oregon Funding

- *No ADRC grant, and still none.*
- What funding sources were used to support implementation of the SPE?
  - *State General Funds and Older Americans funds, and funds raised locally from AAA's, no additional funds from the beginning. State took attitude "we don't care how, just don't ask us for more money"*
- What funding sources are used to support the ongoing operations of the SPE?
  - *It always comes down to State's ability to match federal $$.*

10

Oregon Process

- Did your state start with one target population and then roll out the SPE system to other targeted populations (for example: disabled, youth) – What were your state's lessons and insights? In hindsight, what could be done differently?
  - *Disabilities community originally part of it. Later, in the 80's disability advocates said wait, they like concept, but didn't want to be a part of program mainly for seniors, and "by the way, also some younger people with disabilities". So then it became optional for local offices to set up entry system to include disability population, or not include them. A Separate advisory council has been set up for disability community*
- Did your state test the SPE by setting up a demonstration site?
  - *Yes, used Demonstration counties, including Don's in 1979*
- If your state utilizes the 211 systems, caregiver support system, etc., how did those systems work together? What worked, what didn't?
  - *Not currently statewide*

11

Oregon Process cont.

- What role did federal level agencies, such as CMS or AoA, play in the establishment and ongoing operations of the SPE?
  - *CMS had to approve some waivers, and Older American Act $$$ have been part of the mix from the beginning 1981*
- If your state has an ADRC grant, how were ADRC activities integrated into SPE processes?
  - *Still no ADRC grant*

12

Oregon Operation

- Does your state have a standardized tool to assess consumers utilizing the SPE? How and by whom was the tool developed?
  - *Yes, universal**, IF** putting them onto any LTC portion (but not everywhere, ie. ADL for nutritional services)*
- What types of information and assistance does your SPE provide, i.e. Options Counselors?
  - *No Option Counselors currently in most (some more sophisticated local agencies do). This is a possibility if move to ADRC*
- What are the hours of operation of the SPE?
  - *AAA hours 8-5 (some do have 24 help line)*

13

Oregon Challenges

- What challenges or difficulties did your state encounter in your SPE process?
  - Biggest: State has de-invested, thus contracted services, for PURELY budget implemented considerations: ie. Oregon no sales tax; senior programs 1st in line for cuts. State has been great on Medicaid, but more resources needed into non-Medicaid portion.
- How did you tackle the challenges of streamlining the SPE system?
  - *Movement underfoot to get ADRC and make more sophisticated and statewide*
- What advice would you give to a group pursuing this?
  - *"When it works it is a win, win."*
  - *Note Oregon has decreased (not held even) nursing home population every year for last 20 years. For Oregon, key has been to continue to reinvest.*
  - *Central to success is good case management, always tougher, takes more time, ongoing, problems like turnover*
- Was there resistance to the SPE idea/process?
  - *Original concern about putting Medicaid dollars into SPE, that it would increase demand on state budgets because too many people would demand service, but that has not been the case. Saved money.*
  - *AAA fear would lose focus, become more about LTC, but this was overcome because first of all it was optional, and the more and more came on as they saw this was not the case.*

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Oregon Education/Marketing

- *Literature, talked with hospitals, met with; word of mouth, media, including national*

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Oregon Record System for SPE

- Not used for SPE
- Did the state create an information database to identify what services were being delivered to seniors (or target population group) and/or what services seniors (or target population group) need?
  - *Do have a common data-base, but with movement toward state system, more central screening system 800# could be possibly added, not currently there.*

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Oregon Next Steps (from AARP office)

- ***The current ADRC plan has been drafted by AAA and Statue Unit on Aging (SUA) staff. Presented to key stakeholders (AARP, SEIU and LTC industry) in May.***
- ***SUA and one AAA just wrote a grant proposal to CMS which would secure $ for a SPE/ADRC in one county as effort to pilot for future expansion.***
  - ***Grant includes pilot on discharge planning and follow through with county's hospitals, too.***
- **Using OAA $, state signed up to use the Network of Care web site and had all AAAs have resource info placed on site.**

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Nevada Background from AARP office

- Set up by 2003 legislation, primarily through 211 system.
- The new ADRC's integral part of endeavor.
- Has continued to switch gears as new things come up. It was a phone line and website concept originally – with a brochure, became the 211 system (with dreams of an integrated info and referral system for one form to apply for everything with shared info – which has not exactly been realized)…
  - and then now the 211 combined with ADRC. Part of it is the reality of where the money is at the time. The grants for the ADRC's became available and seemed a good fit.
- Funding (lack of) is a major issue

18

Nevada Survey Info.

- Filled out by Mary Liveratti
  - Deputy Director of Nevada Dept of Health and Human Services
- Mary is the 211 person that has become part of the focus of SPE.

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Nevada Partners

- Who were the identified partners in design of the SPE (both formal and informal)?
  - For the 2-1-1 system: *State govt. (Health and Human Services, Information Technology/Telecommunications), county govt, United Ways, telephone association, telephone providers, NV. Eldercare/Caregiver support, Aging Services, Crisis Call Center, HELP of So. NV, NV Public Health Foundation, Family advocates, NV Disability Advocacy & Law Center.*
- Who were the identified partners in implementation of the SPE (both formal and informal)?
  - *Same as above and, governor's office, legislators, social service providers, AARP, disability and senior groups/advocates.*
- Who were your partners in the ongoing process of SPE?
  - *Same as above, with additional agencies, such as Health Division,(and Health Preparedness), State Business and Industry*
- What internal process did you use to complete the work of establishing a single point of entry?
  - *2-1-1 grew out of the NV Commission on Aging's public hearings on establishing a single point of entry. By partnering with the United Ways, the focus changed to 2-1-1. The Legislature passed a resolution to establish a work group on 2-1-1 and single point of entry with DHHS providing leadership with the United Ways. Since Aging Services was part of the coalition, when Nevada received the ADRC grant, it folded into the on-going efforts.*

20

Nevada Funding

- What were the funding sources identified to support the SPE design and implementation?
  - *Tobacco settlement dollars, state general funds, United Way funds, local funds, Originally we hoped to receive telephone surcharge funding (1 cent would have generated about $500,000) but this was killed by the phone companies.*
- What entities are helping with funding?
  - *State Government, United Ways, Health Preparedness funds. We also received some "one shot" funds through the Casey Family Foundation and a United Health Care settlement.*
- Were there funding "champions"? *(I.e. Governor, legislator, etc.)*
  - *Yes, we have several legislators who have fought for funding. DHHS also put a line item in our budget last session for 2-1-1.*
- If state dollars were used, what strategies were used to inform the state legislature?
  - *Coalition members were able to work with several legislators to propose legislation concerning 2-1-1*.

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Nevada Funding cont.

- What funding sources were used to support implementation of the SPE?
  - *Tobacco dollars, UW and state general funds.*
- What requirements do identified funding sources have? What have been the outcomes, negative and positive?
  - *One shot money is easy to get, the on-going funding was difficult at first. As people have seen the benefit, including legislators, we have received more stable funding through the state. We have not had a statewide manager for the system, but United Way has given us a grant to hire one for the next two years. We also need a data coordinator.*
- After implementation of the SPE, was there an increase in the number of clients who needed to access home and community-based services?
  - We have not done an analysis of this. in the first two years, we have struggled with just implementing the service and maintaining it.
- Was any cost analysis completed regarding how much the State saved by having a SPE system in terms of delaying clients' needs for more costly institutional care options? *NO*

22

Nevada Enacting Legisation

- Two bills were considered during the 2003 legislative session. SB 239 did not pass. We negotiated for the SCR 11 to pass, because SB 239 required us to establish the system, but did not appropriate any funding to do it.
- Set up the coalition in 2003 and had the governor appoint the 211 partnership by executive order several years later.
- System actually started in February 2006. We have had additional bills, for example one in our 2007 session to appropriate funding.

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Nevada Process

- Did your state start with one target population and then roll out the SPE system to other targeted populations (for example: disabled, youth)
  - *NO we rolled the system out to the whole state at one time*
- Did your state test the SPE by setting up a demonstration site? noWere existing systems used?
  - *Yes, the two call centers were experienced as helplines: Crisis Call Center in the north and HELP of So. NV in the south.*
- If your state utilizes the 211 systems, caregiver support system, etc., how did those systems work together? What worked, what didn't?
  - *We've been lucky to have a good working relationship. The fact that DHHS was involved helped these systems to work together (sister agencies).*
- What role did federal level agencies, such as CMS or AoA, play in the establishment and ongoing operations of the SPE?
  - *Very little*
- If your state has an ADRC grant, how were ADRC activities integrated into SPE processes?
  - *Both are part of the coalition for 2-1-1. good working relationship.*

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Nevada Operation

- What programs are included in the SPE program eligibility determination, for example, Medicaid state plan services, Medicaid HCBS wavier services, nursing facility, Older Americans Act programs/services, state-funded programs/services, and other?
  - *This is being developed by the ADRC.*
- Does your state have a standardized tool to assess consumers utilizing the SPE?
  - *Yes*
- How and by whom was the tool developed?
  - *Coalition members*
- What types of information and assistance does your SPE provide, i.e. Options Counselors?
  - *2-1-1 is basic information and referral (more screening activities and connecting to resources); the ADRC provides more eligibility assessment and assistance.*
- What are the hours of operation of the SPE?
  - *2-1-1 is available M thru F, 8 am. To midnight, sat and sun 8 to 4. we plan to go 24 hours, 7 days a week this year.*

25

Nevada Challenges

- Was there resistance to the SPE idea/process?
  - *Biggest resistance was from some service providers who were concerned that it would compete with them for limited program dollars.*
- How were issues resolved?
  - *Communication and trying to find ways to help providers. Many providers use the system for information themselves.*
- What were the outcomes?
  - I B*elieve problem has been resolved, as people have seen the benefit of the system. We had a harder time prior to implementation*

26

Nevada Challenges cont.

- What challenges or difficulties did your state encounter in your SPE process?
  - ******Funding****** *was the biggest challenge. On going, the challenge is policy development, i.e. inclusion/exclusion policy, data policy, oversight of the system.*
- How did you tackle the challenges of streamlining the SPE system?
  - *I don't know that we've tackled that yet. We are in the process of developing a strategic plan for the system.*
- What advice would you give to a group pursuing this? learn from other states.
  - *We talked to others who had successfully implemented the system. We also belong to AIRS and got help from them. Partnerships are vital –both public and private.*

27

Nevada Evaluation

- What does your state's SPE look like now? How is it different from the SPE vision the state may have started with?
  - *Pretty similar. It would be wonderful to link to case management services, which is what we hope will happen with the ADRCs.*
- Has access improved for the population identified/targeted?
  - *We expected about 24,000 calls the first year, but received double that amount (50,000)*
- Has empirical data been collected to verify outcomes?
  - *Data has been collected, but no formal evaluation has been conducted.*
- Has duplication of services been reduced?
  - *Unknown at this time*
- Was access streamlined for all populations?
  - *We have not done a formal evaluation, but believe it to be so based on the numbers calling.*
- Was access streamlined for individual populations?
  - *Appears to be for seniors and people with disabilities.*

28

Nevada Education/Marketing

- Who are the primary referral sources to the SPE and how did the state approach and educate the primary referral sources and targeted individuals about the SPE?
  - *(Physicians, faith communities, family, friends, neighbors, discharge planners, etc?) agency referrals, family/friends, TV PSAs. All grantees of the DHHS are required to be listed with 2-1-1, that helped their awareness. We also built off the United Way I and R system.*
- How did the state approach and educate the target population groups about SPE?
  - *Print articles, TV and radio PSAs.*
- Did the state specifically direct marketing efforts to consumers who were financially secure and/or consumers receiving public assistance?
  - *Only direct marketing efforts have been direct mailing to foster care parents (through the Casey funding) and booths at senior health fairs.*

29

Nevada Records

- Does the state utilize electronic health records in its SPE?
  - *Not at this time*
- Did the state create an information database to identify what services were being delivered to seniors (or target population group) and/or what services seniors (or target population group) need?
  - *Yes we do track what referrals are made and what services are needed, but may not be available.*

30

Maryland Partners

- Who were the identified partners in design of the SPE (both formal and informal)?
  - *State Dept of Disabilities, Advocates (MD Disabilities Law Center, MD Disabilities Council (AARP Exec Council Member was co- chair)*
- Who were the identified partners in implementation of the SPE (both formal and informal)?
  - *Dept of Aging, local heath dept in Worcester County and Howard County Office of Disabilities*
- Who were your partners in the ongoing process of SPE?
  - *Same*
- How did you coordinate information from other executive branch agencies?
  - *MAP Advisory Council*

31

Maryland Funding

- What were the funding sources identified to support the SPE design and implementation? Are hospitals and/or other entities that use these SPE resources for greater efficiency, deferring work to other entities and saving money helping fund the implementation or the ongoing operations? If so, what entities are helping with funding?
  - *Federal and local counties (Worcester and Howard) Baltimore City and Prince Georges Counties will be next. After that, plan for next target is the Lower E. Shore where 7 hospitals will be participating.*
- Were there funding "champions"? (I.e. Governor, legislator, etc.)
  - *Stuart Rosenthal (currently Chair of the State Commission on Aging was a representative of the Commission to the MAP Advisory Council and a strong advocate for SPE. He is also publisher of a newspaper called the Beacon, which is targeted to the senior community.*
- If state dollars were used, what strategies were used to inform the state legislature?
  - *The Dept of Aging made budget presentations to the House and Senate budget Committees.*
- What funding sources were used to support implementation of the SPE?
  - *Combo of Federal, state and local. Fed is expected to be phased out. State and local governments are expected to continue.*

32

Maryland Process

- Did your state start with one target population and then roll out the SPE system to other targeted populations (for example: disabled, youth) – What were your state's lessons and insights? In hindsight, what could be done differently?
  - *Adults w disabilities, including elderly.*
  - *The programs vary with each County. In one jurisdiction it is run by the health dept, in another by the disabilities agency. Baltimore City will be run through the Center for Independent Living. It is designed for maximum flexibility. The website will hopefully provide info on a County by County basis.*
- To what extent was legislation necessary to establish the SPE system in your state (could we have a copy of the legislation?)
  - *MAP is not in statute yet, but expected to be in the future. Senior Information and Assistance Program was adopted through legislation in 1982.*
- If your state has an ADRC grant, how were ADRC activities integrated into SPE processes?
  - *MD has an ADRC grant. MD uses the "No Wrong Door" system. Eventually they will be the same.*

33

Maryland Operation

- What programs are included in the SPE program eligibility determination, for example, Medicaid state plan services, Medicaid HCBS wavier services, nursing facility, Older Americans Act programs/services, state-funded programs/services, and other?
  - *Goal is to include all of these on the website.*
- Does your state have a standardized tool to assess consumers utilizing the SPE? How and by whom was the tool developed?
  - Yes, by Dept. of Aging, chief of housing, Stephanie Hull
- What types of information and assistance does your SPE provide, i.e. Options Counselors?
  - *Options Counseling and direct service where eligible.*

34

Maryland Records

- Does the state utilize electronic health records in its SPE?
  - *No. Plan is to have it by county on the State website so that a case worker can access records from the secured website*
- Did the state create an information database to identify what services were being delivered to seniors (or target population group) and/or what services seniors (or target population group) need?
  - *The Dept of Aging is creating County based databases.*

35

Maryland further info.

- *For further information: best contact is Stephanie Hull, currently chief of housing for the Dept of Aging for Maryland. She ran the SPE program, and knows the logistics of its day to day operation.*

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– xxx –

http://www.iowa.gov/elderaffairs/services/SinglePointOfEntry.html

New Jersey background from AARP

- The State has issued two reports that give an overview of our new LTC law. Many answers to questions can be found in these reports. You can find the most recent report online at http://www.state.nj.us/health/senior/documents/idc_report_108.pdf
- The report paints a rosy picture and does a good job explaining the positives. Answers in questionnaire reflect some of our concerns and points out the negatives

37

New Jersey background cont

- There are two types of SPEA. The old NJEASE and the new ADRC
- NJEASE
  - This program has been up and running in each county in NJ since the mid-90's. It was implemented by the State with and through the Divisions on Aging in each county and it is done well in some counties and poorly in others. In general though, it has been a disappointment since too few people use it, probably because many do not know about it, and/or staff is limited.
  - The NJ EASE Counselors help link callers to Medicaid state plan services, Medicaid HCBS wavier services, nursing facility, Older Americans Act programs/services, state-funded programs/services, and other local services.
- ADRC is the new model being rolled out in about 8 counties. It has been up and running in two pilot counties for two years but there has been no formal assessment done.

38

New Jersey Process

- Did your state test the SPE by setting up a demonstration site? Were existing systems used?
  - There were two pilot counties. These counties were already doing much of what the state envisioned. There has been no formal assessment of the success of these counties.
- If your state utilizes the 211 systems, caregiver support system, etc., how did those systems work together? What worked, what didn't?
- To what extent was legislation necessary to establish the SPE system in your state (could we have a copy of the legislation?)
- What role did federal level agencies, such as CMS or AoA, play in the establishment and ongoing operations of the SPE?
- If your state has an ADRC grant, how were ADRC activities integrated into SPE processes?
  - Many of these answers are in the annual report.

39

New Jersey Funding

- There are no separate state figures assessing the use of these services. The state monitors by looking at federal expenditures on Medicaid dollars.

40

New Jersey Fast Track Eligibility Evaluation (from Auerbach memo)

- *(from page 3)* "Although there has been an evaluation of the ADRC model under the AoA grant, there is no evaluation reported on the cost-effectiveness of either fast-track eligibility, the new client assessment instrument or the client-tracking system. Only fast-track is being implemented statewide at this time."
- *(page 6: #3)* "The Fast-Track eligibility system appears to be approving very few people. The 1/1/08 report states that 625 people were referred for financial screening using Medicare Part D Low-Income Subsidy data and 45 were approved, 82 were already on Medicaid and were referred for further clinical eligibility. In the 10/07 report, it states that clinical eligibility was done first before the names were screened by the Part D data. Was this a change over a few months and, if so, why wasn't it noted? "

41

New Jersey Operation

- Does your state have a standardized tool to assess consumers utilizing the SPE? How and by whom was the tool developed?
  - The state is rolling out the implementation of a SAMS technology system which is intended to track individuals in a uniform manner. The system is only in place in some areas of the state and no data has been issued from the technology to date.

42

New Jersey Challenges

- What challenges or difficulties did your state encounter in your SPE process?
  - Swift and full implementation.
- What advice would you give to a group pursuing this?
  - Require specific timelines for the roll out. Have diligence in monitoring the progress the state is making. Establish measurement tools to evaluate success.
- Was there resistance to the SPE idea/process? If so who or what group resisted? How were issues resolved? What were the outcomes?
  - The issue has not been resolved. We continue to put pressure on the Commissioner of Health and Senior Services to make the roll out in all 21 counties a priority.

43

New Jersey Evaluation

- There have been no state studies of the success/failure of the pilot counties.
  - This is a significant problem in evaluating the success of the state's LTC plan.
- The state expects the new SAMS database system that is being rolled out gradually will begin to answer some of these questions.
  - However, it is not clear that the database can be manipulated in ways to address these questions.

44

New Jersey Education

- How did the state approach and educate the target population groups about SPE?
  - There has been virtually no $$**spending**$$ on outreach and education.
- Did the state specifically direct marketing efforts to consumers who were financially secure and/or consumers receiving public assistance?
  - No.

45

New Jersey Records

- Does the state utilize electronic health records in its SPE?
  - No.
- Are there recommendations about software, computer systems?
  - A commission has been established by a law that will review the use of e-HIT in New Jersey. To date, I do not think members have been appointed to this Commission.

46

Illinois background

- Illinois has not yet adopted a model for Single Point of Entry however there are three ADRC's running in the State and a number of other efforts around Illinois to improve access and awareness by having a coordinated entry point where people can find the services they need.
- There are three ADRC's running in Illinois, two are operated by an Area Agency on Aging and one is operated by a case management organization (CCU) for the HCBS Waiver program.
  - Currently the case management groups and AAAs both have members that feel they should be the single point of entry.
    - This disagreement is a big obstacle in moving forward on SPE at a state wide level.
  - Interestingly the other obstacle is that a number of organizations have made branding efforts in the past and going forward at a statewide level may feel like reinventing the wheel for those that have done some branding already.
- Outside of the ADRC's there are a number of other efforts that are related to SPE that may also help in this discussion

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Illinois background cont.

- The first is the City of Chicago's 311 senior services phone number that has been throroughly branded in Chicago and is identifiable by most seniors in the area. Since most older adults that need services in Chicago know that number, it acts as a single point of entry for the city.
- The West Central Illinois Area Agency on Aging in Quincy, Illinois led an effort to house most senior services in one building.
  - This is an excellent example of a physical site single point of entry. Within this one building they have the area agency on aging, adult day services, home care providers, a senior center, nutrition services, case management for waiver services and more.

48

Illinois Partners

- Who were the identified partners in design of the SPE (both formal and informal)?
- Who were the identified partners in implementation of the SPE (both formal and informal)?
- Who were your partners in the ongoing process of SPE?
  - *The AAAs and the CCUs have been involved. Of course, the Illinois Department on Aging as the ADRC grant recipient has been involved. Finally a few years back AARP and other groups put together and Older Adult Services Advisory Committee that advises agencies that provide services to older adults. One of the sub-committees that meets every other month is the Coordinated Point of Entry group that is composed of many different organizations many of them are from either a AAA or CCU but advocacy groups (including AARP), and academic groups participate in this subcommittee as well.*
- How did you coordinate information from other executive branch agencies?
  - *The advisory committee has been critical for this.*
- What internal process did you use to complete the work of establishing a single point of entry?
  - *It is not yet complete.*

49

Illinois Funding

- What were the funding sources identified to support the SPE design and implementation? Are hospitals and/or other entities that use these SPE resources for greater efficiency, deferring work to other entities and saving money helping fund the implementation or the ongoing operations? If so, what entities are helping with funding?
  - *This varies depending on where the individual effort is. Area Agencies on Aging have used many sources of funding to pursue single point of entry relate goals.*
- Were there funding "champions"? (I.e. Governor, legislator, etc.)
  - *Not at a state wide level individual projects may have some. For the ADRC sites the grant funds have been critical.*
- If state dollars were used, what strategies were used to inform the state legislature?
  - *Significant state funds were not specifically appropriated for these efforts.*
- What funding sources were used to support implementation of the SPE?
  - *ADRC grant funds and funds that local efforts were able to pull together from various sources.*
- What funding sources are used to support the ongoing operations of the SPE?
  - *It depends on the model. In most cases the operations fit for Information and Assistance Funding through the Older Americans Act or case management from the waiver program.*

50

Illinois Funding cont.

- What requirements do identified funding sources have? What have been the outcomes, negative and positive?
  - *If operating funds are mostly for operating information and assistance or case management, there is no financial incentive for branding and other site development efforts.*
- After implementation of the SPE, was there an increase in the number of clients who needed to access home and community-based services: If so, did the increase require additional funding to provide these services?
  - *We have not completed implementation statewide. There is not much information on this from individual sites.*
- Was any cost analysis completed regarding how much the State saved by having a SPE system in terms of delaying clients' needs for more costly institutional care options?
  - *No*

51

Illinois Process

- Did your state start with one target population and then roll out the SPE system to other targeted populations (for example: disabled, youth) – What were your state's lessons and insights? In hindsight, what could be done differently?
  - *Each ADRC site was different, they all served older adults but they chose different populations as a second group. One of them did developmental disbilities but I am not aware of rolling out to other populations. There are multiple state agencies that would be involved in serving mixed populations and the Department on Aging has been the only one to really buy into Single point of entry.*
- Did your state test the SPE by setting up a demonstration site? Were existing systems used?
  - *Yes we still have those demonstrations operating. The systems used are mentioned above.*

52

Illinois Process cont.

- *The Older Adult Services Act (included) was the act that established some direction on this and set up the advisory committee.*
- What role did federal level agencies, such as CMS or AoA, play in the establishment and ongoing operations of the SPE?
  - *With the ADRC sites they have provided a lot of guidance and the funding was important as well.*
- If your state has an ADRC grant, how were ADRC activities integrated into SPE processes?
  - *So far they have been well structured demonstrations and they have provided great examples of how to move forward.*

53

Illinois Operation

- What programs are included in the SPE program eligibility determination, for example, Medicaid state plan services, Medicaid HCBS wavier services, nursing facility, Older Americans Act programs/services, state-funded programs/services, and other?
  - *This depends on the site. The AAA sites have approached ADRC mostly as information as referral to the proper services and have not done much eligibility determination. They may have done some of the OAA services but there is not much that needs to be collected for eligibility determination.*
  - *The CCUs do eligibility determination for state HCBS waiver services and assisting other Medicaid services by assisting with Medicaid applications.*
- Does your state have a standardized tool to assess consumers utilizing the SPE? How and by whom was the tool developed?
  - *The subcommittee on Coordinated point of entry has discussed and worked on this but has not gotten anything concrete yet.*
  - *The CCUs have recently adopted a comprehensive assessment tool that is intended to determine eligibility for a wide range of services beyond just the waiver services. This is a sizable tool and it may not make sense to use this on every person that goes to the SPE*
- What are the hours of operation of the SPE?
  - *Depends on the site. I believe that most are standard business hours.*

54

Illinois Challenges

- What challenges or difficulties did your state encounter in your SPE process?
  - *Other than previously listed, the biggest challenges, in my opinion, are joining branding efforts and determining the organization that will be the SPE.*
- How did you tackle the challenges of streamlining the SPE system?
  - *Yet to be determined.*
- What advice would you give to a group pursuing this?
  - On a local level get the groups involved together on this early. If those groups develop a branding strategy it may be difficult to ask them to allow a unified brand to supercede the one they have already developed.
- Was there resistance to the SPE idea/process?
  - *Not the idea but there are still some issues with the process as mentioned above.*
- If so who or what group resisted? How were issues resolved? What were the outcomes?
  - *There have not been statewide resolutions but most of the individual demonstrations have not had too much trouble finding ways to work through those issues in their community.*

55

Illinois Evaluation

- Has access improved for the population identified/targeted?
  - *The individual sites have improved access.*
- Has empirical data been collected to verify outcomes?
  - *The ADRCs sites are collecting data but have not been released.*

56

Illinois Education/Marketing

- Who are the primary referral sources to the SPE and how did the state approach and educate the primary referral sources and targeted individuals about the SPE? (Physicians, faith communities, family, friends, neighbors, discharge planners, etc?)
  - *Varies by region.*
- How did the state approach and educate the target population groups about SPE?
  - *There has not been a single approach from the state level. This is mostly left to regional entities. The state has made some effort to brand a single point of entry but it has not yet succeeded.*
- Did the state specifically direct marketing efforts to consumers who were financially secure and/or consumers receiving public assistance?
  - *They have not done much but the emphasis has been mostly lower income consumers.*

57

Illinois Records

- Does the state utilize electronic health records in its SPE?
  - *No, but AARP is working on getting electronic health records within health care. Their use in HCBS services have only been discussed on a theoretical level.*
- Are there recommendations about software, computer systems?
  - *Not yet*
- Did the state create an information database to identify what services were being delivered to seniors (or target population group) and/or what services seniors (or target population group) need?
  - *Not yet. This has been another challenge. Some of the stakeholders have been using benefits checkup but there are data bases that the State has pursued. The outputs from the data bases they are pursuing are not yet clear.*

58

Nebraska background

- No real SPE, and no ADRC grant
- The Care Management Program (CMP) is probably as close as we have to a single point of entry program.
  - The program does not authorize funding for services. It assesses need, works with clients to develop a plan of care and then helps mobilize resources to implement that plan of care using formal and informal resources in the community.

59

Nebraska CMP background

- The program was initiated by area agencies on aging. The key to the enactment of legislation in 1987 was the election of an AAA staff member to the Unicameral. That person became the champion of the concept in the Legislature.
- The program started 1989. The administration was not particularly supportive of the program and didn't make implementation a priority.

60

Nebraska CMP background cont.

- The program struggled along, but was successful due to the efforts of the AAAs.
- Not much support for the program outside the aging network.
- Coordination with other program was facilitated when area agencies on aging were given the responsibility for providing the case management for the HCBS Waiver program in 2000.
  - Getting that step in place was done over the objections of the Medicaid agency which had been doing the case management.
  - Moving that function to the AAAs allowed for HCBS Waiver growth and provided some relief on Care Management caseloads.

61

Nebraska CMP funding

- CMP is primarily state-funded.
  - Neither Older Americans Act nor Medicaid funds are used (and no ADRC grant)
  - AAAs supplement program funding with discretionary state and local funding.
  - State funding provides optimal flexibility to serve everyone who needs to be served regardless of income level.

62

Nebraska CMP Process

- The CMP authorizing statutes say that it is for persons who need long-term care.
- Practically, since it is administered by area agencies on aging it is for older people who are not Medicaid eligible, but have low incomes.
  - Recently, the median age of a CMP client was 80.
  - 80% had incomes below 150% of poverty, but few are currently eligible for Medicaid. However, if admitted to a nursing facility, they would be eligible almost immediately.
  - A CMP demonstration was implemented prior to enactment of state legislation. When pre-admission screening was implemented, the enabling legislation called for two demonstration projects.
  - Nebraska has a fairly strong caregiver support network. There is a state-funded respite program. Those programs vary in the degree of integration with CMP.
  - There is a 211 system in the state which, in my opinion, has failed to make a significant impact.

63

Nebraska CMP Operation: Care Managers & Standardized Tool

- Care managers will attempt to utilize any resource to develop and implement a plan of care. Since they cannot authorize services, they must be creative and often use informal services in the care plans.
  - If formal programs are used the client must go through the eligibility process for that program. In some instances (SSBG for example) the program has established a cooperative eligibility screening process with the CMP.
- The Care Management Program operates during normal business hours.
- There is a standardized tool that is used.
  - Original tool developed by the University of Kansas Medical Center.
  - In 1990s, the tool was revised by the Department on Aging in consultation with care managers to better elicit the information they needed to develop effective care plans.

64

Nebraska CMP Operation cont

- One of the outgrowths of the CMP was legislation to require pre-admission screening for Medicaid-eligible applicants for nursing facility care.
  - Hospitals (specifically hospital social workers) were the primary opposition to PAS.
    - The work of the social worker is to discharge patients in a timely manner. A pre-admission screening process was viewed as an impediment to fulfilling that work.
    - PAS has staff on call on weekend

65

Nebraska CMP Operation cont.

- CMP referrals come primarily through the aging network.
  - Plans early in the program's development to engage in an extensive publicity campaign, but the referrals started coming in and quickly tapped the capacity of the program.
  - I have concerns right now that the program is overextended. Some CM workers are following more than 100 individuals who need long-term care.
- CMP has a sliding fee scale reimbursement system.
  - Clients with income over 150% of poverty must pay a portion of the cost of the program. Those with incomes above 300% of poverty pay full cost.
  - Care management generally costs about $50 per hour. This statutory provision has resulted in the vast majority of the clients having incomes below 150% of poverty

66

Nebraska CMP Evaluation

- In the early years of the program, as it was found that the program was having a positive effect in reducing nursing home overutilization, the Department on Aging prepared annual reports for the program that showed that counties where care management was used more extensively were experiencing a reduction in nursing facility utilization rates. While those where it was not being used were experiencing increased rates.

67

Nebraska CMP Eval. cont.

- The CMP did increase demands for some services. Emergency response systems saw an increase in demand, along with the need for in-home supports. Most of the increased demand was in the IADL type of service.
- Cost analysis from Medicaid expenditure data:
  - Medicaid spending for long-term care for the 65+ population is $20 million less than what we would have expected it to be in FY-07 if spending had grown at the rate of inflation using FY-00 as a base year.
  - Medicaid spending for people over 65 grew 27.2% in FY-91 and an additional 20.2% in FY-92. That growth was driven by nursing home spending.
    - By gearing up the CMP, we began to turn the utilization of nursing homes down. Average annual growth in Medicaid spending for people over 65 from FY-85 to FY-96 was 12.0%. From FY-96 to FY-07 the average annual growth rate was 3.6%.

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Nebraska CMP Eval. cont.

- Access has been enhanced and independent living has been supported. Nebraska's nursing home population peaked in 1993 at 17,769. By 2006, the nursing home population had fallen to 13,804.
- The age group that has seen the steepest decline in utilization has been the 85+ age group. The under 65 utilization rate has actually increased, so there is a need to better address the needs of younger adults with disabilities.
- Streamlined access is difficult to measure. At various points in the development process we have looked at methods of addressing the most challenging access issues.
  - It is difficult for community-based long-term care providers who have to mobilize a variety of service providers to compete for the affection of hospital discharge planners, with nursing homes which provide a single point of contact and an immediate yes or no answer.
- One of the challenges is developing a supply of high quality independent contractors who can provide in-home IADL and ADL support. We have had legislation in the past two sessions to create a long-term care worker registry. The registry would provide a better means of identifying, recruiting, deploying, training and compensating in-home service workers, particularly in rural areas. I see that as the next step in the evolution of our system.

69

Nebraska Records

- A database was developed within the aging network to comply with AoA NAPIS reporting requirements.
  - The system was built out to try to provide management and planning information. It was a difficult build. (Unsure of its current status)

70

Minnesota background

- See website: www.Minnesotahelp.info
- The Senior Linkage Line is very popular and well known to folks in Minnesota and to the extent that the Linkage Line refers people to this site, it will be well used for referrals to home and community based services for example.
- It appears as though the SPE has expanded beyond senior services, such as youth services, military services, etc. so it has the look and feel of being a true one-stop shop for services for folks if they are looking.

71

Minnesota background cont.

- The challenge of course is to get people aware of the site and to get them looking at it. It still a challenge to increasingly make it a widely publicized resource. It has also gone through some renovations since its inception a couple of years ago, so I expect some of that will continue to shake out to make the website useful and popular to use.
- Minnesota has a very strong home and community based services structure and people become aware of the availability of these services in a number of ways. I believe at this time it is likely the county, or the folks who have immediate impact during crisis time that refer people to services. It is my impression that DHS is working toward getting people (county case workers, families, discharge planners, law/policy makers, etc) familiar with this site so it can be a truly one-stop shop, but it is also my impression that work needs to be done to get there in Minnesota.

72

Minnesota Process

- Site was rolled out to seniors and recently expanded to include others.
- To my recollection there was a demonstration site.
- Minnesota does have a 211 system
- Minnesota receives funding from ADRC

73

Minnesota Operation Senior LinkAge Line (info. from '05 article)

- "As a senior or caregiver uses the online tool, he or she builds a self-care plan, which includes caregiver, community and home-based resources.
- The self-care-plan developer includes six questionnaires about memory loss, medicine, health insurance, housing and housekeeping, safety and security, and estate planning.
- Each area uses in-depth assessment questions that provide information to the community resource plan."

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Minnesota Operation Senior LinkAge cont. (info. from '05 article)

- Minnesota… "is planning to work with hospital discharge planners and other health-care organizations."
  - "With this information, it is hoped that the tool will be used to review care options, including home- and community-based types of services."

75

Minnesota Education/Marketing (info. from '05 article)

- Senior Surf Days and similar programs
  - Community education to learn about the decision support tool as it is integrated in the overall curriculum for computer training.

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Minnesota ADRC project link w/ LTC Transparency

- Quality and Cost of LTC
- See included slide show

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